e Court, U.S.
I L E D

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In the

Supreme Court of the United States

JOHN B. RAMIREZ AND
JOSE MICHAEL MANGAWANG

Petitioners

v.

THE STATE OF TEXAS
and
ROBERT LOISEAU, SPECIAL DEPUTY RECEIVER
FOR AMERICAN BENEFIT PLANS

Respondents.

ON PETITION FOR WRIT OF CERTIORARI TO THE
TEXAS SUPREME COURT

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Does the McCarran-Ferguson Act empower the State of Texas or any state to regulate or interfere with the federal taxation powers of the federal government?

2. Does a Texas state court have the jurisdiction to render a judgment on the legal existence of self funded single employer ERISA benefit plans and their designated trust if federal law mandates that any judgment involving "interpretations of ERISA" are the exclusive subject matter jurisdiction of Federal U.S. District Courts?

3. Does a Texas state court or any state administrative tribunal have the jurisdiction to "deem" a self funded single employer ERISA benefit plan or its designated trust to be an unauthorized insurer or a Multiple Employer Welfare Arrangement (MEWA) when federal law mandates that such judgments involving "interpretations of ERISA" are the exclusive subject matter jurisdiction of Federal U.S. District Courts?

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PETITION FOR WRIT OF CERTIORARI

Petitioners John B. Ramirez and J. Michael Mangawang as the trustees of the trust of 649 self funded single employer ERISA benefit plans and fiduciaries of those same plans respectfully petition for a writ of certiorari to vacate the judgment rendered by the Texas state courts against the Petitioners and allow Petitioners to refile their Cross-complaint in a U.S. District Court of competent jurisdiction in light of this court's recent decision in *Montemayor v. Corporate Health Ins.*, - U.S. -, 122 S.Ct. 2617 (2002), and the subsequent decision by the Fifth Court of Appeals on remand from the U.S. Supreme Court cited as *Corporate Health Insurance, Inc.; Aetna Health Plans of Texas, Inc.; Aetna Health Plans of North Texas, Inc.; and Aetna Life Insurance Company v. Texas Department of Insurance; Jose Montemayor; John Cornyn, Case No. 98-20940 decided on 12/16/2002.*

OPINIONS BELOW

The unpublished decision of the Texas Supreme Court denying Petitioner's Petition For Review is set forth in the Appendix hereto as **(A - 1).** The opinion of the Texas Third Court of Appeals is not yet published, but will be published in the Southwest Reporter, and as of this date it has been assigned the following number by West Group - 2003 WL 21241261, and is set forth in the Appendix hereto as **(A - 2).** The unpublished decision of the Texas District Court is set forth in the Appendix hereto as **(A - 3).** The unpublished Findings of Fact and Conclusions of Law of the Texas District Court is set forth in the Appendix hereto as **(A - 4).** The unpublished decision of the U.S. Fifth Circuit Court of Appeals Case No. 98-20940 decided on 12/16/2002 is set forth as **(A - 9).** The unpublished order of U.S. District Court remanding Case No. A-02-Ca-220-SS to Texas District Court is set forth in the Appendix hereto as **(A-12).**

STATEMENT OF JURISDICTION

The Texas Supreme Court entered its judgment on October 17, 2003, in which it denied a petition for review of the Texas Third Appeals Court decision entered on May 30, 2003, affirming the Texas District Court's decision in the case of The State of Texas v. American Benefit plans, et al. There has been no order granting an extension of time to file the petition for a writ of certiorari. This petition for a writ of certiorari has been filed within ninety (90) days of October 17, 2003. Petitioners invoke this Court's jurisdiction under 28 U.S.C. § 1257(a).

CONSTITUTIONAL PROVISIONS, TREATIES, STATUTES, ORDINANCES, AND REGULATIONS OF QUESTIONS PRESENTED

United States Constitution: Article VI

> This Constitution, and the laws of the United States which shall be made in pursuance thereof; and all Treaties made, or which shall be made, under the Authority of the United States, shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the contrary notwithstanding.

The Employee Retirement Insurance Security Act of 1974 (ERISA)

The operative ERISA regulations involved in the questions presented are as follows:

(a) 29 U.S.C. § 1101, 29 U.S.C. § 1102, and 29 U.S.C. § 1103 with regards to the existence, creation and regulation of self-funded single employer ERISA benefit plans;

(b) 29 U.S.C. § 1144 (b)(2)(B), 29 U.S.C. § 1144 (b)(6)(C), and 29 U.S.C. § 1144 (d) regarding the ERISA preemptions;

(c) 29 U.S.C. § 1132 regarding the exclusive subject matter jurisdiction of the federal court in matters "relating to" ERISA and the standing necessary to bring suit against an ERISA plan and its fiduciaries.

U.S. Department of the Treasury Regulations 26 U.S.C. § 419A(f)(6) and 26 U.S.C. § 501(c)(9)

26 U.S.C. § 419A(f)(6) involves the taxation regulations of self-funded single employer ERISA benefit plans.

26 U.S.C. § 501(c)(9) involves the IRS regulations relating to the recognition of exempt status of the trust of a self-funded single employer ERISA plan.

Texas Insurance Code 100.014

Codifies the intention of the Texas State Constitution that the Texas Insurance Code cannot conflict with any law of the United States.

Texas Constitution Article 1

Sec. 1. FREEDOM AND SOVEREIGNTY OF STATE. Texas is a free and independent State, *subject only to the Constitution of the United States*, and the maintenance of our free institutions and the perpetuity of the Union depend upon the preservation of the right of local self-government, unimpaired to all the States.

STATEMENT OF THE CASE

The Petitioners in this case, John B. Ramirez a/k/a Johnny Rhondo and Jose Michael Mangawang, are trustees of United Employers Voluntary Employees Beneficiary Association I, (herein "UEVEBA I") that obtained a recognition of exemption as a 29 U.S.C. § 1103

tax exempt non-profit 26 U.S.C. § 501 (c)(9) trust for self-funded single employer ERISA plans on August 28, 1995.

During the year 2001, 649 individual employers established self funded single employer ERISA welfare benefit plans for their employees with the help of American Benefit Plans who aided the employers in establishing their own ERISA plans by creating and enacting plan documents. Each employer then contracted with a third party administrator to manage and administer the contributions made to their respective plans.

Effective July 1, 2001, each of these employers adopted UEVEBA I, as their 29 U.S.C. § 1103 tax-exempt non-profit plan trust, by adopting the UEVEBA Trust Document, and signing a plan adoption agreement.

The employers then contracted with third party administrators to pay claims and benefits from the employer contributions. The employers then decided to obtain reinsurance policies in order to insure that there would always be sufficient funds to pay for any and all resulting claims. Several insurance companies agreed to provide reinsurance contracts under the condition that the third party administrators transfer the employer contributions to the reinsurance companies to hold in trust against the payment of future claims.

The employers, through designated representatives, instructed their third party administrators to transmit their contributions to the reinsurance companies, and instructed the reinsurance companies to issue the insurance policy to their designated trust UEVEBA I. UEVEBA I was then charged with the task of holding the reinsurance policies as an asset, in trust, for each of the 649 self funded single employer ERISA plans, and provide year end accounting for each of the 649 plans in accordance with the ERISA reporting and disclosure requirements per 26 U.S.C. § 419A(f)(6) and 26 U.S.C. § 501(c)(9).

When the fiduciaries of UEVEBA I discovered that the deposited funds were not being released by the reinsurance companies to the third party administrators to pay claims, they reported this violation of ERISA to the U.S. Department of Labor (herein "DOL") who to this date has not finished its review of this matter.

On or about March 17, 2002, the Respondent State of Texas obtained a Temporary Restraining Order, sought a Temporary Injunction, a Permanent Injunction and received an Order Appointing a Receiver upon the allegation that the Petitioners were engaged in the "unauthorized business of insurance". **(A - 5)** The Receiver, the Texas Commissioner of Insurance through his Special Deputy Receiver, subsequently filed a corresponding action in California against UEVEBA I, et al.

On March 28, 2002, the Respondent obtained an Interim Temporary Injunction and set for trial - a Temporary Injunction hearing for May 28, 2002.

On April 2, 2002, Petitioners removed the Texas State action to the Western Federal District Court in Austin, Texas and filed their Cross-Complaint against the Special Deputy Receiver, and the State of Texas Insurance Commissioner in Federal Court.

On April 5, 2002, Petitioners removed the California State Action to the U.S. Central District Court in Santa Ana, CA. and filed their Cross-Complaint against the Texas Special Deputy Receiver

On May 3, 2002, the Texas Special Deputy Receiver answered the California Cross Complaint but did not take any actions to remand the action back to the California State Court.

On May 24, 2002, Petitioners received information from one of the Texas Defendants that the "removed action" had been "remanded" back to Texas State Court

(This was the Friday before the Memorial Day weekend). and that a hearing on both Temporary Injunction and Permanent Injunction would be held on May 28, 2002. The Petitioners were never informed by opposing counsel as to the remand or what would be litigated at the May 28, 2002 hearings.

On May 28, 2002, hearings for both the Temporary Injunction in the morning and the Permanent Injunction in the afternoon were held. At the Permanent Injunction Hearing, Hon. Scott H. Jenkins, from the District Court of Travis County, Texas 53rd Judicial District rendered the judgment in favor of the permanent injunction for the State of Texas and dismissed the cross-complaint by the fiduciaries of UEVEBA I against the Texas Commissioner of Insurance. Within the week, the Petitioners, filed a motion requesting a hearing for a new trial.

On July 15, 2002, a hearing was held on Defendants' Motion For a New Trial. When the Defendants' Motion was denied, John B. Ramirez and Jose Michael Mangawang filed a timely appeal of the May 28th decision to the Texas Third Court of Appeals. The opposing parties were the State of Texas Attorney General and the Special Deputy Receiver for the Texas Department of Insurance.

On June 28, 2002, Petitioners requested the U.S. Central District Court in California to make the Special Deputy Receiver provide tax information so that they could comply with their fiduciary obligations of filing federal 990 tax returns on behalf of the trust of the 649 plans. The District Court ruled that the tax information sought by Petitioners should be obtained from the Texas Receivership Court.

On July 2, 2002, the Special Deputy Receiver filed a motion for Contempt of Court against Petitioners because they him asked for tax information to file their requisite federal 990 tax returns with the Internal Revenue

Service. The Special Deputy Receiver later withdrew this motion.

On July 22, 2002, Petitioners filed a request to release tax information in to order file Form 990 with the Internal Revenue Service with Special Master Tom Collins and the Texas Receivership Court.

On August 7, 2002, Petitioners filed a Notice of Appeal of the May 28th decision to the Texas Third Court of Appeals.

On August 12, 2002, Special Master Tom Collins and the Texas Receivership Court *denied* Petitioners' request to release tax information in order file Form 990 with the Internal Revenue Service. Petitioners were forced to file an incomplete 990 return. **(A - 6)**

On September 24, 2002, Special Deputy Receiver made an application to the Texas Receivership Court for the authority to use an alternative health plan benefit proof of claim processing procedure, and to classify claims. The Petitioners immediately filed an opposition to Special Deputy Receiver's application, and filed their own request for the payment of claims to be made in accordance to 29 U.S.C. §§ 1102-1144 and the plan provisions of the 649 single employer plans.

On October 24, 2002, the Texas Receivership court granted the Special Deputy Receiver's application to classify and pay claims according to an alternative health plan benefit proof of claim processing procedure; and not in accordance to each ERISA Plan's provisions. **(A - 7)**

On May 30, 2003, the Texas Third Court of Appeals rendered its judgment to affirm the lower court's decision by concluding that the Petitioners offered a multiple employer welfare arrangement (MEWA) subject to state regulation *merely* because the assets of the plans were pooled, and overruled all of the Petitioners' issues. The Texas Third Court of Appeals justices who participated in

the decision were Justices Mack Kidd, Lee Yeakel and Patterson, with the author of the opinion being Justice Jan P. Patterson.

On July 28, 2003, Petitioners timely filed a Petition for Review to the Texas Supreme Court.

On October 17, 2003, the Texas Supreme Court denied the Petitioner's Petition For Review.

STATEMENT OF HOW THE TEXAS SUPREME COURT, THE TEXAS APPEALS COURT AND THE TEXAS DISTRICT COURT ABUSED THEIR DISCRETION

The Texas District Court abused its discretion by failing to recognize that the State of Texas violated 29 U.S.C. § 1144(b)(2)(B) by "deeming" that the trust and trustees of the self-funded single employer ERISA plans were unauthorized insurers and involved in the "business of insurance". It also abused its discretion by refusing to recognize the existence of 649 self funded single employer ERISA plans. Further, it abused its discretion by interpreting issues "related to" ERISA while knowing that issues are the exclusive subject matter jurisdiction of the U.S. District Courts, and that such jurisdiction is prohibited to the states by 29 U.S.C. § 1132(e). It also abused its discretion with regards to its obligation under the Supremacy Clause of the U.S. Constitution by rendering a judgment when it knew that it lacked the jurisdiction to do so. *The federal question of the state court's jurisdiction was raised in Petitioners" pre-tiral brief and during the testimony of Petitioners Ramirez and Mangawang.* **(A - 5)**

The Texas Third Court of Appeals abused its discretion because it affirmed the judgment of a lower court that did not have the authority or jurisdiction to render a judgment in violation of 29 U.S.C. § 1132(e) that confers exclusive subject matter jurisdiction over matters

"relating to" ERISA with the U.S. District Courts. The Appeals Court also made the determination that the Petitioners were offering a MEWA, and by so doing it also violated 29 U.S.C. § 1132(e), and the Supremacy Clause of the U.S. Constitution by rendering a judgment knowing that it lacked the jurisdiction to do so. *The federal question of the state appellate court's jurisdiction was raised in the briefs filed by the Petitioners.*

The Texas Supreme Court abused its discretion by allowing its lower courts to render judgments in violation of 29 U.S.C. § 1132 that confers exclusive subject matter jurisdiction over matters "relating to" ERISA to the U.S. District Courts, failing to recognize the lack of standing of the State of Texas to bring this suit, and consciously failing to correct the mistakes of the lower courts by refusing to hear Petitioner's Petition for Review. *The federal question of the subject matter jurisdiction was raised in the Petition For Review filed by the Petitioners.*

In this case, the State of Texas is not only in violation of Article VI of the U. S. Constitution, ERISA and Texas Insurance Code 100.014, but also Article 1 of the Texas State Constitution that prohibits state law from conflicting with federal law.

REASONS FOR GRANTING THE WRIT

1. The Texas State decision is in direct conflict with the decisions of other Courts of Appeal and the U.S. Supreme Court and in particular the recent court case of *Montemayor v. Corporate Health Ins.*, - U.S. -, 122 S.Ct. 2617 (2002) that was decided on remand by the U.S. Fifth Court of Appeals on December 16, 2002. **(A - 9)**

2. The Texas State decision is in direct conflict with the provisions of 26 U.S.C. § 419A(f)(6) that require single employer plans to "pool" their contributions to prevent employers from redirecting contributions for purposes other than providing health and welfare benefits to their

employees, and to prevent carry-over of excessive unused contributions from one year to the next. **See (A - 11)**

3. Because the Texas State judgment nullifies the federal tax benefits given to self-funded single employer ERISA plans by Congress, it is in direct violation of Article VI of the U.S. Constitution.

4. The failure to grant certiorari will undermine decades of ERISA preemptive protections and set a dangerous precedent that would allow State Courts to avoid their obligation set forth in the Supremacy Clause of the U.S. Constitution that prohibits the subrogation of federal law to state law.

5. The failure to grant certiorari will set a dangerous precedent that would allow the States to eviscerate ERISA by allowing them to *ignore* the existence of self funded single employer ERISA benefit plans, as the State of Texas did in this case, by allowing States to "deem" the trust and trustees, inseparable component parts of self funded single employer ERISA benefit plans, to be "unauthorized insurers" in violation of 29 U.S.C. § 1144(b)(2)(B)

ARGUMENT

The Texas District Court, the Texas Third Court of Appeals and the Texas Supreme Court (herein the "Texas Courts") made and upheld a blatantly erroneous and invalid judgment because these state courts lack the *jurisdiction* and *authority* to render a valid judgement over self-funded single employer ERISA benefit plans.

In a sense, this case might even be considered one of *res judicata* since this is the same Texas Insurance Commissioner, Jose Montemayor, who previously attempted to regulate self-funded single employer ERISA benefit plans through an independent claims review procedure. Because this attempt was appropriately stopped by the U.S. Fifth Circuit Court of Appeals, he is

now attempting to regulate self-funded single employer ERISA benefit plans by "deeming" the *trust* of self funded single employer ERISA plans to be an "unauthorized insurer" in a state court action. Similar tactics have been attempted in other circuits and failed because the circuit courts have recognized that 29 U.S.C. § 1144(b)(2)(B) and 29 U.S.C. § 1144(d) specifically prohibit this conduct. See *Bell v. Employee Sec. Ben. Assoc.*, 437 F.Supp 382, 1EBC 1703 (1977, DC Kan); *Eversole v. Metropolitan Life Ins. Co.* 500 F.Supp 1162 (1980, CD CA); *Ramsey County Medical Center v. Breault* 189 Wis 2d 269, 525 NW2d 321, 18 EBC 2741 (1994, App).

A State Court Lacks Subject Matter Jurisdiction To Render Any Judgment That Relates To A Self-Funded Single Employer ERISA Benefit Plan

It has been well established that to be enforceable, a judgment *must* be supported by three elements; (1) the court have jurisdiction of the parties; (2) the court must have jurisdiction of the subject matter; and (3) the court or tribunal must have the power of authority to render the particular judgment. Subsequently, a decision is facially void if an inspection of its record proper shows that *one* or more of the requisite judgment elements appears to have been absent. *Messenger v. Messenger* (Okla) 827 P.2d 865 (1992).

Further, jurisdiction refers to two different concepts: (1) the power of a court to render a valid judgment, and (2) the propriety of granting the relief sought. It is only when a court lacks fundamental jurisdiction to render a judgment that there is an absence of authority in the court so as to render its judgment a nullity. *Dorsey v. State*, 295 Md 217, 454 A.2d 353 (1983).

In this case, it is the Texas District Court, the Texas Third Court of Appeals, and the Texas Supreme Court that lacked both the jurisdiction of subject matter and the

power of authority to render a judgment over the Petitioners and UEVEBA I, the designated trust of 649 self-funded single employer ERISA benefit plans.

In the first place, the Texas courts presiding over this action lacked jurisdiction because 29 U.S.C. § 1132(e) states that any matter that "relates to" ERISA is the exclusive subject matter jurisdiction of the federal courts. Because UEVEBA I is the ***trust*** of single employer ***ERISA*** plans, in accordance to 29 U.S.C. § 1132(k), only a federal court, has the statutory authority to render a valid judgment in a matter that "relates to" ERISA. On the other hand, 29 U.S.C. § 1132(e) *does not* grant statutory authority to a state court to render a valid judgment in a matter that "relates to" ERISA.

Courts all over the country have struggled for years on what exactly "relates to" ERISA actually means. However, all federal courts have been consistent in the position that if ERISA needs to be interpreted - the interpreting body must be a Federal District Court. The judge in the Texas District Court, *on the record*, took judicial notice of 29 U.S.C. § 1144(b)(2)(B). It is truly inconceivable why he deliberately ignored the fact that the subject entities were self-funded single employer ERISA plans, and subsequently refused to recognize that he had no jurisdiction over these entities, their trust and its fiduciaries. By so doing, the Texas District Court violated Article VI of the U.S. Constitution, the Supremacy Clause, by placing a state interest over its obligation to uphold the supremacy of the United States and its courts.

Secondly, the Texas District Court lacked not only subject matter jurisdiction, it also lacked the statutory authority to render a judgment over the Petitioners and the 649 single employer ERISA benefit plans.

Texas Courts obtain their authority first from the U.S. Constitution and then from the Texas Constitution.

Congress gets its law making authority from the U.S. Constitution. By enacting ERISA and particularly, 29 U.S.C. § 1132, it is clear that Congress statutorily authorized federal courts to adjudicate any matter "relating to" the interpretation of ERISA to the exclusion of state courts.

However, 29 U.S.C. § 1132(e) not only specifies the authority of a federal court to exercise its exclusive jurisdiction over any matter that "relates to" ERISA, it also clearly specifies that subject matter jurisdiction rests *exclusively* with a federal court in order to meet the jurisdictional requirement of a valid judgment. It has been well established that a judgment rendered by a court which has no jurisdiction over the subject matter of the action or proceeding is void. *Blume v. United States* (DC SD 40 BR 551) (1984); *Commodity Futures Trading Com. v. Nahas*, 238 US App DC 93, 738 F.2d 487 (1984); *State v. Turner, 98 Wash* 2d 731, 658 P.2d 658 (1983); *See also 20 Am Jur 2d, Courts §§ 95,97,105.*

Because 29 U.S.C. § 1132(e) places both the statutory authority and subject matter jurisdiction with the federal courts to the exclusion of state courts, in matters "relating to" ERISA, the Texas District Court simply did not have the jurisdiction to render a judgment against UEVEBA I and its ERISA fiduciaries.

None the less, in this case, these ERISA protections would come into effect only if the subject entities are self-funded single employer ERISA plans. Unlike the circumstances involved in *Bell, Eversole,* or *Ramsey*, the State of Texas did not "deem" the single employer plans to be involved in the "business of insurance", it "deemed" the 29 U.S.C. § 1103 ERISA *trust* of these plans to be an "unauthorized insurer". **(A - 4)**

To this end the Texas District Court not only abused its discretion, it made a significant judicial error

regarding the subject entities and persons involved in the hearing. For this reason, the status and existence of the 649 self funded single employer ERISA benefit plans and their designated 29 U.S.C. § 1103 trust must now be addressed.

At All Times, The Petitioners Established And Asserted That They Were The Trustees And Fiduciaries Of Single Employer ERISA Benefit Plans Exempt From State Regulation And That The State Courts Lacked Subject Matter Jurisdiction To Render A Judgment Against The Plans, Their Trust And Fiduciaries

The existence of the 649 single employer ERISA welfare benefit plans has never been refuted, **(A - 4)** and the court record provides ample unrefuted testimony and documentary evidence that they were established according to 29 U.S.C. § 1102 and 29 U.S.C. § 1103 and *Donovan v. Dillingham,* 688 F.2d 1367 (11th Cir. 1982) which states that an employee benefit plan under ERISA is "*established*" if, from the "*surrounding circumstances,*" a reasonable person can ascertain the four elements of an ERISA plan:

(a) Plan benefits, "Adoption Agreement"

(b) a class of beneficiaries, "Adoption Agreement"

(c) the source of financing "Adoption Agreement"

(d) procedures for receiving benefits "Basic Plan Document"

Additionally, for a self-funded ERISA single employer employee benefit plan, the required method of delivering benefits is through a trust such as the "UEVEBA I Trust Document". In order to take maximum tax advantages, the trust must also be qualified under 26 U.S.C. § 501(c)(9) and be a multiple employer plan trust under 26 U.S.C. § 419A(f)(6).

The 649 single employer plans also passed the litmus test established by *MD Physicians & Assoc. Inc v. State Board of Insurance*, 957 F.2d 178 (5th Cir. 1992), which establishes that for single employer ERISA plans to escape state regulation under 29 U.S.C. § 1003(a), the determining factors are:

1) whether an employer established or maintained the plan, and

2) whether the employer intended to provide benefits to its employees."

There is clear and convincing evidence, *provided by the Respondent*, who introduced over 40 actual plan adoption agreements into evidence, (10 of which are attached hereto as **(A - 10)**) that the employers established and maintained their single employer plans for the purpose of providing benefits to their own employees and not any other employer's employees. Further, since the assets held by UEVEBA I *belong* to a single employer plan and complete control of the account thereof resides with the employer, it is the employer that provides the benefit and not UEVEBA I. Thus, both the self-funded single employer plan and its trust are not subject to state law in accordance to 29 U.S.C. § 1144 (a). See also *Pilot Life Insurance v. Dedeaux*, 481 U.S. 41, 107 S.Ct. 1549, 95 L.Ed.2d 39 (1987) and *FMC Corp. v. Holliday*, 111 S.Ct. 403 (1990).

Therefore, because the 649 single employer benefit plans meet the requirements of 29 U.S.C. § 1102 and 29 U.S.C. § 1103, *Donovan, MD Physicians, Pilot Life Insurance,* and *FMC Corp.,* they are in fact, and in law, self funded single employer ERISA benefit plans with a non-profit tax exempt 29 U.S.C. § 1103 ERISA trust whose fiduciaries are the Petitioners. Further, both the plans and their fiduciaries are subject to both ERISA liabilities and protections.

Significantly, the findings of fact and conclusions of law issued by the Texas District Court **(A - 4)** never established that UEVEBA I was not the designated trust of the 649 single employer plans, but did recognize that the Petitioners were the fiduciaries of that entity. On the other hand, the plan document, the trust document and over 40 of the 649 signed plan adoption agreements were provided both to the Texas District Court and the Texas Third Court of Appeals by the Respondent.

Since the existence of the 649 plans has been well established by the court record to be self-funded single employer ERISA plans with a designated 29 U.S.C. § 1103 trust, we can now turn to how 29 U.S.C. § 1144(b)(2)(B) specifically denies any state court from rendering a judgment against a self-funded single employer ERISA plan and its designated 29 U.S.C. § 1103 trust.

The Provisions Of 29 U.S.C. § 1144 (b)(2)(B) Deny The States Statutory Authority Over Self-Funded Single Employer ERISA Benefit Plans

There can be no argument that a Texas state court can exercise jurisdiction over an "unauthorized insurer" since it obtains that statutory authority from the Tex. Ins. Code Ann § 101.051 and 101.102. However, because 29 U.S.C. § 1144(b)(2)(B) prevents a trust of a single employer ERISA plan to be "deemed" by a state authority to be an "insurer" or "engaged in the business of insurance", Tex. Ins. Code Ann § 101.051 and 101.102 cannot be applied to the 649 single employer ERISA plans, its trust UEVEBA I, or its fiduciaries. "Thus, if a court is authorized by statute to entertain jurisdiction in a particular case only, and undertakes to exercise the jurisdiction conferred in a case to which the statute has no application, the judgment rendered is void." *McLellan v. Automobile Ins. Co.,* 80 F.2d 344 (9th Cir. 1935); *State ex. rel. Yohe v. District Court*, 33 Wyo 281, 238 P 545 (1925).

The Petitioners filed a pre-trial brief with exhibits containing an extensive discussion as to why the continuation of the injunction was prohibited by ERISA, and why Texas had no statutory authority to regulate UEVEBA I, and each of the self funded single employer ERISA benefit plans. The Texas District Court, *on the record*, even took judicial notice of 29 U.S.C. § 1144 (b)(2)(B). **See (A - 5)**

In order to declare UEVEBA I an "unauthorized insurer" under Texas Insurance Code § 101.051 and § 101.102, Texas had to rely on the regulation that allows the states concurrent jurisdiction with the U.S. Department of Labor in the regulation of MEWAs, in accordance with 29 U.S.C. § 1144 (b)(6)(A)(ii). Unfortunately, the state statutes that Texas relied upon for its authority are in conflict with 29 U.S.C. § 1144(b)(2)(B) when applied to UEVEBA I, the trust of self-funded single employer ERISA plans. Additionally, 29 U.S.C. § 1144 (b)(6)(A)(ii), from which the state derives all of its asserted authority to regulate UEVEBA I is superceded and rendered null and void in its application by 29 U.S.C. § 1144(b)(6)(C), which states,

> Nothing in subparagraph (A) shall affect the manner or extent to which the provisions of this subchapter apply to an employee welfare benefit plan which is not a multiple employer welfare arrangement and which is a plan, fund, or program participating in, subscribing to, or otherwise using a multiple employer welfare arrangement to fund or administer benefits to such plan's participants and beneficiaries.

However, even if Texas still insists that UEVEBA I is a MEWA, 29 U.S.C. § 1144 (b)(6)(A)(ii) still does not give it jurisdiction over an ERISA plan trust established in accordance with 29 U.S.C. § 1103 because it is superceded by 29 U.S.C. § 1144(d), which states:

> Nothing in this subchapter shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States (except as provided in sections *1031* and *1137*(c) of this title) or any rule or regulation issued under any such law.

Even If UEVEBA I Was A MEWA It Would Still Be Exempt From State Regulation Under 29 U.S.C. § 1144(b)(6)(C)

It was absolutely essential for the State of Texas to make a finding that UEVEBA I was a MEWA in order for jurisdiction to be maintained in a state court action pursuant to 29 U.S.C. § 1144 (b)(6)(A)(ii). However, even if UEVEBA I was a MEWA, The State of Texas would still be preempted by 29 U.S.C. § 1144(b)(6)(C) from undertaking any form of state regulation.

In *Crull v. Gem Insurance Company*, 58 F.3d 1386, (1995), the U.S. Ninth Circuit Court of Appeals found that all state law claims are preempted by ERISA, even if the trust of the plan is a MEWA, as long as a single employer plan provides the plan participant's benefit.

In accordance to 29 U.S.C. § 1103, the provider of employee benefits is each individual single employer ERISA plan - not UEVEBA I, which merely functions as the trust of plan assets. Since UEVEBA I does not provide any plan benefit, it cannot possibly be deemed to be a MEWA subject to state law because a MEWA, by definition, is a *provider of benefits*.

Finally, UEVEBA I itself, cannot statutorily be the provider of any benefit to any employee because, under ERISA, all potential beneficiaries of the Trust already collectively own *all* of the UEVEBA I's assets from which their benefits may be paid.

All State Laws Are Preempted By ERISA If They Are Applied To The ERISA Plan Trust of Self-

Funded Single Employer ERISA Plans And No State law Is Saved From Preemption By The Application of 29 U.S.C. § 1144 (b)(2)(A) Or By The McCarran Ferguson Act

The court record clearly shows evidence, testimony, with objections to the jurisdiction of the Texas District Court indicating that the Petitioners were the trustees of the trust of self funded single employer ERISA plans that did not engage in any "business of insurance". However, the Texas Third Court of Appeals found that Texas has authority over the Petitioners because the Petitioners "pooled" single employer plan assets within UEVEBA I, the ERISA trust of 649 self funded single employer ERISA plans. Since the U.S. Fifth Circuit Court of Appeals had already established in *Montemayor v. Corporate Health Ins.* just six months previously, that state laws do not apply to self funded single employer ERISA plans, the Third Court of Appeals had to rely on the *McCarran Ferguson Act* to justify its judicial authority over the Petitioners in order to validate the lower court's judgment. The Petitioners will now discuss why the Texas Third Court of Appeals was incorrect in its reasoning and conclusion.

It is particularly significant that in *Montemayor,* the U.S. Fifth Circuit Court of Appeals determined that by enacting 29 U.S.C. § 1144 (b)(2)(B), Congress has unmistakably ordained that no insurance law of the State of Texas may be applied to a self funded single employer ERISA plan. Therefore, as a result of *Montemayor*, no Texas Insurance Law can apply to the statutorily requisite ERISA trust of 649 self-funded single employer ERISA plans or its fiduciaries, the Petitioners.

ERISA's preemptive legislative history clearly demonstrates that Congress has consistently rejected any provision preempting only inconsistent or duplicative state laws in favor of preemption of the entire field of

employee plan regulations. As documented in the *120 Congressional Record 29942 (1974)*, Senator Javits concluded that, "[T]he emergence of a comprehensive and pervasive Federal Interest and the interests of uniformity with respect to interstate plans require but for certain exceptions – the displacement of state action in the field of employee benefit programs". Further supporting Congressional intent, Senator Harrison Williams Jr. stated, as documented in *120 Congressional Record 29933 (1974)*, that, "preemption {of state law} in the field {of commerce} is intended to apply in its broadest sense with only the exceptions specified in the act {ERISA}."

In this particular case, the Texas Commissioner of Insurance Jose Montemayor, acted under the authority of Texas Insurance Code which he felt permitted the insurance commissioner to "deem" persons or other entities as "unauthorized insurers" or to declare them to be persons or entities engaged in the "business of insurance".

However, the preemption of the Texas insurance laws by ERISA as applicable to the UEVEBA I is preserved by 29 U.S.C. § 1144(b)(2)(B) which states that "any employee benefit plan established under ERISA cannot be deemed to be an insurer or engaged in the business of insurance". UEVEBA I is the statutorily necessary 29 U.S.C. § 1103 designated ERISA plan trust of 649 self funded single employer ERISA plans in accordance to *Donovan*. Therefore, as a consequence of the "*deemer clause*", no state insurance law can be applicable to UEVEBA I or its fiduciaries.

The State of Texas also sought to escape ERISA preemption of its insurance laws by asserting the authority 29 U.S.C. § 1144 (b)(6)(A)(ii) (herein the "MEWA Law") over UEVEBA I and its fiduciaries. 29 U.S.C. § 1144 (b)(6)(A)(ii) states that any ***state insurance law*** that is not in conflict with ERISA may be applicable to a Multiple Employer Welfare Arrangement (herein "MEWA") as defined in 29 U.S.C. § 1002(40).

However, the MEWA law cannot give the State of Texas any authority directly or indirectly over the Petitioners or UEVEBA I because the MEWA law can only permit a state to apply its *state* regulatory powers over an insurer or any person engaged in the "business of insurance".

In *Shaw v. Delta Air Lines, Inc.* 463 U.S. 85, 96-97, 103 S.Ct. 2890, 2899-2900, 77 L.Ed.2d 490 (1983). the U.S. Supreme Court clearly established that a state may not use ERISA, in this case the MEWA law, to expand any state regulatory powers. In accordance with *Shaw*, Texas cannot use the MEWA law to expand its regulatory powers to encompass entities such as UEVEBA I or the Petitioners who statutorily cannot be deemed to be insurance entities or engaged in the business of insurance. Thus, Texas laws are unconditionally preempted because neither the ERISA "savings clause", 29 U.S.C. § 1144 (b)(2)(A), nor the ERISA MEWA provision, 29 U.S.C. § 1144 (b)(6)(A)(ii), can give Texas any regulatory authority over *any ERISA plan trust* such as UEVEBA I.

Since the Texas action against the Petitioners is preempted by ERISA, the decision by the Texas Court of Appeals is wrong on four counts.

First, since the "savings clause" of ERISA does not save Texas Insurance laws from ERISA preemption, and the ERISA fiduciaries of a 29 U.S.C. § 1103 ERISA trust are beyond the jurisdiction of Texas law, the *McCarran Ferguson Act* cannot be used as an alternative means to save Texas Law from preemption, It is inconceivable that Congress would remove state jurisdiction over an ERISA plan and its trust by enacting 29 U.S.C. § 1144(b)(2)(B), and then permit a state to circumvent preemption by invoking *McCarran*.

In fact, *McCarran* is self limiting in this regard, when it stipulates that "[n]o Act of Congress shall be construed

to invalidate, impair or supersede any law enacted by any State for the purpose of regulating the business of insurance, "unless such Act specifically relates to the business of insurance." The legal principle espoused by *McCarran* is that it cannot supercede any Act of Congress that specifically relates to insurance. 29 U.S.C. § 1144(b)(2)(B) specifically relates to insurance since it prevents any state from deeming an ERISA plan or its ERISA Trust to be an insurer or engaged in the "business of insurance".

Congress' power over the regulation of insurance is absolute because the "business of insurance" is a field of interstate commerce as defined by the court in *UNUM Life Ins. Co. of Am. v. Ward*, 526 U.S. 358 (1999). In the application of *McCarran*, Federal courts have generally held that Federal regulation of a field of commerce, such as insurance, should not be deemed to preempt state regulatory powers *unless*, "the nature of the subject matter permits no other conclusion" or "Congress has unmistakably so ordained". *Florida Lime and Avocado Growers, Inc. v. Paul*, 373 U.S. 132, 142, 83 S.Ct. 1210, 1217, 10 L.Ed.2d 248 (1963). See also, *Jones v. Rath Packing Company* 430 U.S. 519, 525, 97 S.Ct.1305, 1309, 51 L.Ed.2d 604 (1977).

In this case, the regulated subject matter (the subject matter being the existence of an ERISA plan) permits "*no other conclusion*" that the insurance laws of the State of Texas are unconditionally preempted by ERISA from applying to an ERISA plan or its trust because it has been "*so ordained*" by Congress by the enactment of 29 U.S.C. § 1144(b)(2)(B). Also, ERISA preempts the application of Texas law to the Petitioners because they, as ERISA fiduciaries, are statutorily inseparable from the ERISA plans and their Plan Trust. See *DOL Regulation 2510.3-101(k)(2).*

ERISA's "savings clause" and *McCarran* both serve the same national policy and utilize the same terminology to

define that what is left to the states are laws that "regulate insurance" under ERISA, and "laws regulating the business of insurance" under *McCarran*. The two statutes are in *pari materis* and should be construed consistently. *See United States v. Conforte*, 437 F.Supp 641, 654 n.7 (D. Nev 1978), *aff'd* 624 F.2d 869 (9th Cir. 1980). Clearly Congress intended that *McCarran* cannot be used to give any state any regulatory power over the ERISA plan trust if that regulatory power is not saved by the ERISA "savings clause".

Second, the Petitioners are merely the trustees of the designated trust of self funded single employer ERISA plans whose actions are always determined by the ERISA Plans' Administrators. It was the Plan Administrators, not the Petitioners, who decided to pool the assets of their respective plans for the purpose of deducting their plan contributions which would otherwise not have been fully deducible. The persons who pooled the assets of the single employer plans were each plan's named ERISA fiduciary, the employer, over which all state laws are preempted in accordance with 29 U.S.C. § 1144 (a) and 29 U.S.C. § 1144(b)(2)(B). See also *MD Physicians*.

All of the Petitioners activities which the Texas Commissioner asserts were the unauthorized practice of insurance were only performed in accordance with their ERISA fiduciary responsibility, and duty to prevent the disallowance of the employer contributions which pay for ERISA plan benefits. If the employer contributions were not deductible then the employers would be considerably less inclined to pay for employee benefits which is a consequence directly in conflict with the intent of Congress when it enacted ERISA and provided the tax incentives related thereto. **See (A - 9)**

Third, the Texas Courts erroneously decided that the mere act of pooling assets is an act of engaging in the "business of insurance". The pooling of employer plan assets is required under 26 U.S.C. § 419A(f)(6) in order

for employers to fully deduct employer contributions in excess of claims paid or payable during the employers fiscal year. The requirement to pool employer assets has been affirmed in the landmark U.S. Tax Court case of *Boothe v. Commissioner*, 108 U.S. Tax Court Reports 524, (1997), (herein, "Boothe"), and set forth in writing by the final IRS regulations. **(A - 11)**.

In *Boothe,* the employers' contributions to a trust, such as the UEVEBA I, were disallowed for the sole reason that they did not pool their assets within their Plans' common trust. The employers' contributions were disallowed because they did not comply with the pooling requirements of 26 U.S.C. § 419A(f)(6) which permits employer health and welfare plan contributions to be made and deducted without regard to the deductible contribution limitations set forth in 26 U.S.C. § 419 and 26 U.S.C. § 419A.

In order to promote and encourage the formation and establishment of health and welfare employee benefit plans, Congress enacted 26 U.S.C. § 419A(f)(6) so that 10 or more employers could contribute to a multiple employer trust and thereby exceed the deductible limits set forth in 26 U.S.C. §§ 419 and 419A. However, 26 U.S.C. § 419A(f)(6) is not only a statute which permits the deductions for employer contributions made in excess of claims paid or payable, but, it also prevents the excessive inurement of surplus funds for the benefit of any one employer by requiring that an employer's plan contributions be used not only to pay for the employer's employees' benefits, but also used to pay for the benefits of the employees of at least nine other employers.

In *Boothe*, Judge Laro stated that "The House committee articulated its concern about the tax shelter potential of welfare benefit plans and about the ability of small business owners to achieve the effect of a qualified pension plan but with fewer limitations. *H. Rept 98-432*

(part 2), supra at 1275." Judge Laro further stated that "The committee also noted that 'substantial advanced funding of welfare benefits will ultimately lead [inappropriately] to an unacceptable tax burden for many taxpayers who do not participate in this program'."

In *UNUM Life Ins. Co. of Am. v. Ward,* 526 U.S. 358 (1999), the court found that a state may only exercise regulatory powers over matters which are subject to regulation under state law. Since no state law may regulate 26 U.S.C. § 419A(f)(6) then *McCarran* would not be applicable to those entities, specifically the Petitioners, whose activities were exclusively to comply with the federal statute.

Texas cannot even assert that the mere existence of the incidental inherent element of insurance created by 26 U.S.C. § 419A(f)(6)'s pooling requirement subjects the Petitioners to the state's insurance laws. *McCarran* cannot be invoked to provide Texas with regulatory authority over the Petitioners, because 26 U.S.C. § 419A(f)(6) is a federal law, and any insurance element inherent therein is beyond the reach of *McCarran* which cannot apply to give any state regulatory authority over a federal law which relates to any aspect of insurance

Fourth, the Texas Courts erroneously decided that by holding the pooled assets of self funded single employer plans, UEVEBA I and its trustees were engaged in the "business of insurance". UEVEBA I is a federally tax exempt 26 U.S.C. § 501(c)(9) trust that serves as the requisite ERISA trust for 649 self funded single employer ERISA plans. As a multiple employer plan trust described in 26 U.S.C. § 419(e)(3)(A), UEVEBA I is subject to the provisions of 26 U.S.C. § 419A(f)(6). In order to preserve its trust assets by protecting them from federal taxation, UEVEBA I must hold all of the single employer ERISA plan assets in a single unallocated trust account from which employee benefit payments may be

made to all eligible employees of all employers contributing to the single pooled trust account.

The Internal Revenue Service, in its recent memorandum regarding its final regulations regarding 26 CFR Parts 1 and 602 **(A - 11)** describes a trust which did *not* comply with 26 U.S.C. § 419A(f)(6) as a trust that "is expected to accumulate a surplus that ultimately will be used for the benefit of individual employers (or their employees)". Thus, it is beyond question, that IRS regulations require that single employer plan assets must be held by the UEVEBA I in a single pooled account. It is clearly the Congressional intent that in order for employer contributions to be rendered deductible, trusts like UEVEBA I must hold the assets of 10 or more single employer welfare benefit plans in a single account used to pay any claims made by any participant of any of the plans.

In *IRS Reg. 1.419A(f)(6)-1(c) Characteristics indicating a plan is not a 10 or more employer plan*, the Internal Revenue Service indicated in subparagraph (2) that a plan or fund does not comply with 26 U.S.C. § 419 A(f)(6) "if the assets of the plan or fund are allocated to a specific employer or employers through separate accounting of contributions or expenditures for individual employers or otherwise." Therefore, pursuant to the provisions of 1.419 A(f)(6)-1(c)(2), UEVEBA I, must by federal law hold all of its assets in a single pooled account. This was the very act that the Texas Insurance Commissioner deemed to be "engaging in the business of insurance". For this reason, the Commissioner's actions against the Petitioners, which are no less than a state exercising regulatory powers over federal taxation, are constitutionally prohibited to him, to the State of Texas and its courts thus rendering all judgements and resulting actions illegal, invalid and void.

All Of The Texas State Courts Made Several Other Significant Judicial Errors In Adjudicating This Matter

Ordinarily, because the Texas State Courts lacked the subject matter jurisdiction and the statutory authority to render a valid judgment in this case, we would need to go no further. However, there are errors regarding the Findings of Facts and Conclusions of Law **(A - 4)** that should be addressed because of their ongoing Constitutional violations

First of all, the Judge in the Texas District Court never prepared these Findings of Facts and Conclusions of Law himself. They were prepared for him by Christopher Fuller, Attorney for the Special Deputy Receiver. Judge Jenkins signed the Findings of Facts and Conclusions of Law without a single change.

Considering the fact that he took judicial notice of 29 U.S.C. § 1144(b)(2)(B), and examined plan adoption agreements of self-funded single employer ERISA plans, his resulting Findings of Facts and Conclusions of Law are inconsistent with both fact and law.

It should also be clear that at no time did the Petitioners fail to challenge the jurisdiction of the Texas Courts in this action. This challenge was recognized by the Hon. Sam Sparks in the Western District U.S. District Court in his order to remand Petitioner's removal action back to state court. **(See A - 12)** This challenge is written in the pre-trial brief that was submitted to the Texas District Court prior to the Permanent Injunction Hearing. This challenge was put on the record at the Permanent Injunction Hearing. This challenge continued in the briefs filed with the Texas Third Court of Appeals and the Petition For Review before the Texas Supreme Court. For the Findings of Fact and Conclusions of Law to say otherwise is a misrepresentation.

Another issue that the Texas District Court has refused to consider is the issue of standing to bring a civil suit by the State of Texas. 29 U.S.C. § 1132(a) clearly

specifies that only a beneficiary, Fiduciary or Secretary of the U.S. Department of Labor may bring a civil action against an ERISA plan or its fiduciaries. Since the State of Texas is neither a beneficiary, a fiduciary, nor the Secretary of the U.S. Department of Labor, it clearly lacks the standing to have brought this suit.

Petitioners also disagree with the Texas Third Court of Appeals that stated in its opinion that were was no independent evidence provided by the Petitioners that was presented to prove the existence of the self funded single employer ERISA benefit plans. Over 40 plan adoption agreements were actually provided by the Respondent **(See A - 10)** and two were actually the subject of cross examination by the Deputy State Attorney General. Further, evidence and testimony was introduced by both Petitioners and Respondents such as trust agreements, plan documents, IRS Letters of Recognition for a 501(c)(9) ERISA trust - all of which are the ear marks of self funded single employer ERISA benefit plans that were created by employers for their employees as specified by well established case law.

CONCLUSION

The State of Texas has clearly and blatantly exceeded its federal and state constitutional authority in this matter, and in so doing has violated Article VI of the U.S. Constitution and Article 1 of the Texas Constitution. Because the 649 employer plans were never determined to be other than what the Petitioners claim them to be, i.e., self funded single employer *ERISA* plans, by a federal court of competent jurisdiction - all three Texas State Courts have abused their discretion, made significant judicial errors, and all three of their judgments must be deemed by this Court to be invalid and void for want of subject matter jurisdiction and statutory authority.

A Writ of Certiorari should be granted to the Petitioners for a variety of reasons that are clearly national in scope.

First, the Texas decisions are in direct conflict with the decisions rendered by Federal District Courts, Federal Circuit Courts, and the U.S. Supreme Court.

Second, the Texas decisions are in direct conflict with the expressed intentions of Congress who established ERISA laws and regulations to promote the establishment of self funded single employer ERISA benefit plans in order to relieve our national health care crisis.

Third, there are 649 self-funded single employer ERISA plans all over the country whose contribution deductions are currently in jeopardy of being denied by the IRS because of the Texas Receivership of those plan assets.

Fourth, denial of the writ would set a dangerous precedent that would allow state court judges to avoid their obligation as set forth in the Supremacy Clause of the U.S. Constitution that prohibits the subrogation of federal law to state law.

Fifth, denial of the writ would allow the States to "deem" the trust and trustees of self funded single employer ERISA benefit plans to be "unauthorized insurers" in violation of 29 U.S.C. §1144(b)(2)(B) at their whim.

This Court should also be reminded of the recent court case of *Montemayor v. Corporate Health Ins.*, - U.S. -, 122 S.Ct. 2617 (2002) that was decided on remand by the U.S. Fifth Court of Appeals on December 2002. **(A - 8 & 9)** Here we see the same antagonist (Montemayor) attempting to eviscerate self-funded single employer ERISA benefit plans with only ERISA fiduciaries

standing between him and them. The only difference here is there are a different set of self-funded single employer ERISA benefit plans, and a different set of ERISA Fiduciaries. Montemayor was not successful in 2002, and he should not be allowed to be successful now at the expense of 649 plans, their participants, and the thousands of self-funded single employer ERISA plans all over the country who depend on ERISA's preemptive powers to protect their plan assets.

Wherefore, Petitioners pray,

1. That this Court grant Petitioner's petition for a writ of certiorari and

2. Vacate the Texas judgment and declare it void.

3. Order the State of Texas to give all moneys taken from the 649 self-funded single employer ERISA benefit plans to the U.S. Department of Labor and charge the U.S. Department of Labor with the responsibility of administering claims in according to each ERISA plan's provisions.

4. Grant the Petitioners, as ERISA fiduciaries, the leave to re-file their cross-complaint against the State of Texas, the Permanent Receiver and Special Deputy Receiver in a U.S. Federal Court of competent jurisdiction in order to protect the participants of the 649 self-funded single employer ERISA benefit plans, their designated trust UEVEBA I, and their respective fiduciaries.

Respectfully submitted,

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No._____

IN THE
SUPREME COURT OF THE UNITED STATES
OCTOBER TERM, 2003

JOHN B. RAMIREZ AND
JOSE MICHAEL MANGAWANG
PETITIONERS

V.

THE STATE OF TEXAS
AND
ROBERT LOISEAU, SPECIAL DEPUTY RECEIVER
FOR AMERICAN BENEFIT PLANS
RESPONDENTS

APPENDIX
ON PETITION FOR WRIT OF CERTIORARI TO THE
TEXAS SUPREME COURT

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JOSE MICHAEL MANGAWANG
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Table of Exhibits

1. Texas Supreme Court Decision

2. Judgement of the Third Court of Appeals

3. Trial Court's Final Judgement of the Permanent Injunction

4. Trial Court's Findings of Fact and Conclusions of Law

5. Excerpts of the Texas Permanent Injunction Hearing

6. Texas Receivership Court's Denial of Tax Information to the Petitioners

7. Texas Receivership Court's Order Allowing Claims To Be Paid By The Texas Receiver Not In Accordance With ERISA Plan Provisions

8. Montemayor v. Corporate Health Ins., - U.S. -, 122 S. Ct. 2617 (2002)

9. Corporate Health Ins., Inc. v. Texas Department of Insurance, No. 9820940p - Decided By the U.S. Fifth Court of Appeals on 12/16/2002

10. Excerpts From the State of Texas' Exhibit List Used In The Texas District Court's Hearing For Permanent Injunction Showing Single Employer ERISA Plan Adoption Agreements

11. July 16, 2003 JS-560 Treasury and IRS Issue Final Regulations for "10 or More Employer" Welfare Benefit Fund

12. Order Remanding Case No. A-02-Ca-200-SS from U.S. District Court to Texas District Court

EXHIBIT A - 1

[SEAL]

THE SUPREME COURT OF TEXAS
Post Office Box 12248
Austin, Texas 78711

(512) 463-1312

October 17, 2003

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RE: Case Number: 03-0636
Court of Appeals Number: 03-02-00548-CV
Trial Court Number: GV200903

Style: THE STATE OF TEXAS
v.
AMERICAN BENEFIT PLANS, ET AL.

Dear Counsel:

Today, the Supreme Court of Texas denied the petition for review as redrafted in the above styled case.

Sincerely,
/s/ Andrew Weber
Andrew Weber, Clerk
by Nancy Vega, Chief Deputy Clerk

cc: Ms. Amalia Rodriguez-Mendoza
Ms. Diane O'Neal

EXHIBIT A - 2

TEXAS COURT OF APPEALS, THIRD DISTRICT,
AT AUSTIN

JUDGMENT RENDERED MAY 30, 2003

NO. 03-02-00548-CV

Robert Neal Pointer, Jose B. Ramirez, and
Jose Mangawang, Appellants
v.
The State of Texas and Robert Louiseau, Special Deputy
Receiver for American Benefit Plans, Appellees

APPEAL FROM 53RD DISTRICT COURT OF TRAVIS
COUNTY BEFORE JUSTICESKIDD, YEAKEL AND
PATTERSON AFFIRMED -- OPINION BY
JUSTICE PATTERSON

THIS CAUSE came on to be heard on the record of the court below, and the same being considered, because it is the opinion of this Court that there was no error in the trial court's judgment: IT IS THEREFORE considered, adjudged and ordered that the judgment of the trial court is in all things affirmed. It is FURTHER ordered that the appellants pay all costs relating to this appeal, both in this Court and the court below; and that this decision be certified below for observance.

TEXAS COURT OF APPEALS, THIRD DISTRICT, AT AUSTIN

NO. 03-02-00548-CV

Robert Neal Pointer, Jose B. Ramirez, and Jose Mangawang, Appellants

v.

The State of Texas and Robert Louiseau, Special Deputy Receiver for American Benefit Plans, Appellees

FROM DISTRICT COURT OF TRAVIS COUNTY, 53RD JUDICIAL DISTRICT NO. GV200903, HONORABLE SCOTT H. JENKINS, JUDGE PRESIDING

MEMORANDUM OPINION

Robert Neal Pointer, Jose B. Ramirez, and Jose Mangawang appeal from the trial court's judgment against them in this receivership action.[1] The final judgment appoints a permanent receiver for a number of entities operated by appellants that engaged in the unauthorized sale of insurance, permanently enjoins appellants from continuing with these activities, and imposes civil penalties and costs against appellants. We affirm the trial court's judgment.

Factual and Procedural Background

The State of Texas filed suit to stop appellants' unauthorized sale of insurance, marketed as "American Benefit Plans." Multiple unrelated employers remit monthly contributions and fees to American Benefit Plans, which then contracts with third-party administrators and healthcare networks to administer medical claims, provide a prescription drug program, and provide

[1]Robert David Neal filed a notice of appeal in this cause, but took no further action. Accordingly, he was dismissed as an appellant. *See Pointer v. State*, No. 03-02-548-CV (Tex. App.– Austin March 5, 2003) (order).

access to discounts for medical services. These unrelated employers execute "Plan Adoption and Employer Agreements," enroll in the National Association of Working Americans (NAWA), the United Employers Voluntary Employees Beneficiary Association (UEVEBA) or UEVEBA I. NAWA is designated as the association administrator and UEVEBA or UEVEBA I is designated as the plan trust. Appellants succeeded in enrolling several hundred employers in these health plans designed and marketed by appellants.

Unfortunately, few claims ever were paid. Funds from the participants were commingled. Rather than paying claims, these funds were used to pay salaries and, in one instance, to purchase control of the First American Christian Society, a fraternal benefit organization, for Robert David Neal's family. These activities resulted in the current litigation and injunction against appellants.

Appellants[2] bring ten issues: (1) appellants were themselves victims of American Benefit Plans and Robert David Neal; (2) the court erred in failing to determine whether each of the single-employer welfare benefit plans

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[2]We note that appellants have acted *pro se* in this litigation. However, litigants choosing to act *pro se* must comply with the applicable procedural rules and are held to the same standards that apply to licensed attorneys. *See In re Estate of Dilasky*, 972 S.W.2d 763, 766 (Tex. App.– Corpus Christi 1998, no pet.); *Greenstreet v. Heiskell*, 940 S.W.2d 831, 834-35 (Tex. App.– Amarillo 1997, no writ). To treat the *pro se* litigant differently would accord an unfair advantage over litigants represented by counsel. *See Mansfield State Bank v. Cohn*, 573 S.W.2d 181, 184-85 (Tex. 1978).

Mangawang is an actuary allowed to represent clients in front of the Internal Revenue Service; Ramirez (also known as "Johnny Rhondo") holds several California insurance licenses and describes himself as a "Business Organizational Expert" who combines the skills of a lawyer, accountant, insurance agent, public relations agent and efficiency expert; Pointer holds a degree in advertising design. Appellants Ramirez and Mangawang filed one brief; appellant Pointer essentially adopted the brief of Ramirez and Mangawang; he raised no different issues. All three will be referred to collectively as "appellants."

at issue was in fact a self-funded single-employer welfare benefit plan exempt from state regulation; (3) the court erred in failing to determine whether UEVEBA I was a designated non-profit tax-exempt trust for the self-funded single-employer ERISA welfare benefit plans; (4) the court erred in failing to determine that the self-funded single-employer ERISA welfare benefit plans and their designated trust are exempt from state regulation and cannot be considered to be engaged in the business of insurance; (5) the court erred, by making the determination that UEVEBA is a multiple employer welfare arrangement subject to state regulation without the "substantiated evidence" of a final agency determination from the U.S. Department of Labor; (6) the court erred in failing to determine that ERISA preempted the State's actions; (7) the court erred by dismissing appellants' cross-complaint without notice of the hearing; (8) the court erred in assessing civil money penalties; (9) the court erred in failing to grant a new trial for "procedural violations" by the State of Texas; and (10) the court erred in failing to determine that UEVEBA is not an unauthorized insurer or engaged in the business of insurance. We address these issues grouped as: lack of notice (issues seven and nine); ERISA preemption (issues two, three, four, five, six, and ten); and assessment of penalties (issue eight).[3]

Discussion

Notice

Appellants complain that they did not receive notice of the May 28 setting for the hearing that resulted in the final judgment; appellants urge that this "procedural violation" should have resulted in a new trial.

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[3]Although appellants urge as their first issue that they are "victims" of Robert David Neal, the issue is not briefed and so is waived. *See* Tex. R. App. P. 38.1 (h). We do not, however, find support for this contention in the record.

The record shows that in its "Interim Temporary Injunction" signed March 19, 2002, the district court set a hearing on the permanent injunction for May 28, 2002. Appellants complain that they understood a hearing was set on the permanent injunction, but did not think that the permanent injunction setting included all of the issues in the case. However, a hearing to decide whether to enter a permanent injunction is necessarily a trial of all of the issues in the case. *See Elzondo v. Williams*, 643 S.W.2d 765, 767 (Tex. App.–San Antonio 1982, no writ) (permanent injunction not dependent on any future action by court and grants all relief that court intended to grant in that case); *see also State v. Gibson's Distrib. Co.*, 436 S.W.2d 122, 124 (Tex. 1968) (trial court could not have rendered final judgment or permanent injunction in this case, and cannot until case tried on merits); *cf. Davis v. Huey*, 571 S.W.2d 859, 861-62 (Tex. 1978) (appellate court erred in its review of *temporary injunction* by full consideration of merits of underlying lawsuit; order on remand would give full relief on merits, depriving litigants of jury trial). The temporary injunction order setting the cause stated that the temporary injunctive relief continued "until this case is decided after a final hearing on the merits." *See* Tex. R. Civ. P. 683 (order granting temporary injunction shall include order setting cause for trial on merits with respect to ultimate relief sought).

Further, although appellants participated in the trial on May 28, no appellant complained about lack of notice or the scope of the trial, including action on the cross-complaint, against which a motion to dismiss had been filed. No party moved for a continuance. Accordingly, those complaints are waived. *Hoog v. State*, 87 S.W.3d 740, 745 (Tex. App.–San Antonio 2002, pet. denied) (when party failed timely to object to notice or seek continuance and instead participated in trial, any objection to lack of notice waived); *Manning v. North*, 82 S.W.3d 706, 714 (Tex. App.–Amarillo 2002, no pet.) (when party participates in hearing without notifying court of

any complaint, that party has waived its right to object to lack of notice).[4] We overrule issues seven and nine.

Preemption

The crux of appellants' complaint is that the State of Texas may not regulate their plan as insurance because ERISA[5] preempts any such state action. See 29 U.S.C.A. § 1144(b)(2)(B) (West 1998). However, ERISA does not preempt state regulation in all circumstances. See id. § 1144(b)(6). In reaction to abuses of the ERISA preemption doctrines by entities engaging in illegal insurance schemes, Congress amended the statute to clarify the states' rights to regulate certain "multiple-employer welfare arrangements" (MEWAs) irrespective of whether they otherwise qualified as ERISA plans. *See Atlantic Healthcare Benefits Trust v. Googins*, 2 F.3d 1, 5 (2d Cir. 1993); *Fuller v. Norton*, 86 F.3d 1016, 1023-24 (10th Cir. 1996).

The issue then is whether the plan appellants offered is a MEWA. If so, it is subject to regulation under the Texas Insurance Code.[6] A MEWA is:

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[4]Appellants contended in their motion for new trial that counsel for the receiver misrepresented the scope of the trial. Counsel for the receiver testified that he had stated that the hearing would be on the permanent injunction but did not further elaborate on the scope of relief involved. The court found no misrepresentation. The fact finder is the sole judge of the credibility of the witnesses and the weight to give their testimony. *See Montgomery Indep. Sch. Dist. v. Davis*, 34 S.W.3d 559, 567 (Tex. 2000).

[5]Employees' Retirement Income Security Act, 29 U.S.C.A. §§ 1001-1461 (West 1998, 1999 & Supp. 2002).

[6]The plans that are the subject of this litigation have been found to be MEWAs subject to regulation and "cease and desist" orders have been issued in Arkansas, Colorado, Florida, and Louisiana. The Department of Labor informed the Texas Department of Insurance that it considered the plan a MEWA subject to regulation and that ERISA preemption did not apply. *See* Letter from Office of Regulations

> an employee welfare benefit plan, or any other arrangement... established or maintained for the purpose of offering or providing any benefit... to the employees of two or more employers (including one or more self-employed individuals), or to their beneficiaries, except that such term does not include any such plan or other arrangement which is established or maintained –
>
> (i) under or pursuant to one or more agreements which the Secretary finds to be collective bargaining agreements,
>
> (ii) by a rural electric cooperative, or
>
> (iii) by a rural telephone cooperative association.

29 U.S.C.A. § 1002(40)(A) (West 1999). In a MEWA, liabilities and contributions from multiple unrelated employers are pooled. Appellants claim that they ran 400 discrete single-employer plans. The trial court's finding to the contrary is supported by legally and factually sufficient evidence.

Although Ramirez claimed that 400 discrete single-employer plans existed, he admitted that funds were pooled in a single account. According to the accounting analysis performed upon the appointment of a temporary receiver, funds were freely commingled; there was no documentation of transactions between entities. Tom Petrosewitz, CPA, audited appellants' main office. He was surprised at the disarray of the financial records. There were no formalities observed to distinguish between various plans or claims paid for specific employees to tie to each supposed discrete single-

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and Interpretations, U.S. Department of Labor, to Texas Department of Insurance (Mar. 18, 2002).

employer plan. Kelly Reimers, a member of the receivership staff, testified that the offices were in disarray; piles of paper were everywhere, a general ledger (either physical or computer) could not be found, and there was a general lack of the type of business documents one would expect to find. Appellants' contrary evidence consisted of their testimony and assertions that the plans were ERISA plans not subject to regulation; they did not produce any independent evidence to refute the State's accounting testimony. The trier of fact was free to weigh and even disregard testimony. *See Montgomery Indep. Sch. Dist. v. Davis*, 34 S.W.3d 559, 567 (Tex. 2000). There was sufficient evidence to support the trial court's finding of fact that the plan fit the definition of a MEWA and thus its conclusion that it was subject to state regulation. Accordingly we overrule issues two, three, four, five, six, and ten.

Penalties

Appellants claim that there was a "rush to judgment" that improperly resulted in all four appellants being held jointly and severally liable for administrative penalties. The evidence showed a common enterprise, interrelated entities, common management, and shared responsibility among appellants. The UEVEBA "Policies and Protocols" manual explained that American Benefit Plans designs health-care plans, which NAWA implements. Ramirez and Mangawang ran UEVEBA from offices in California, while NAWA was run by Neal and Pointer from offices in Texas. The activities and enterprises were interrelated and support a joint and several penalty.

Appellants' "rush to judgment" complaint basically reurges the notice complaint previously addressed. Entry of a permanent injunction allows the receiver to set a deadline to file proofs of claim, identify claimants, attempt to pay such claims, begin recouping assets from third parties in other states, and otherwise protect the State's and consumer interests to a greater degree than the interlocutory temporary injunction. Further, there

was no rush to set the permanent injunction hearing – had appellants not removed the case to federal court after the temporary injunction set the hearing on the permanent injunction, they could have focused on dealing with the state court action. We overrule issue eight.

Conclusion

We conclude that appellants offered a multiple-employer welfare arrangement subject to state regulation. We have overruled all of appellants' issues presented and affirm the trial court's judgment.

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Jan P. Patterson, Justice

Before Justices Kidd, Yeakel and Patterson
Affirmed
Filed: May 30, 2003

EXHIBIT A - 3

CAUSE NO. GV200903

IN THE DISTRICT COURT OF
TRAVIS COUNTY, TEXAS
53rd JUDICIAL DISTRICT

THE STATE OF TEXAS,
-Plaintiff

VS.

AMERICAN BENEFIT PLANS; UNITED EMPLOYERS VOLUNTARY EMPLOYEE BENEFICIARY ASSOCIATION; UNITED EMPLOYERS VOLUNTARY EMPLOYEE BENEFICIARY ASSOCIATION I; NATIONAL ASSOCIATION FOR WORKING AMERICANS; NATIONAL ASSOCIATION OF WORKING AMERICANS; ROBERT DAVID NEAL, INDIVIDUALLY AND D/B/A AMERICAN BENEFIT PLANS, UNITED EMPLOYERS VOLUNTARY EMPLOYEE BENEFICIARY ASSOCIATION, UNITED EMPLOYERS VOLUNTARY EMPLOYEE BENEFICIARY ASSOCIATION I, NATIONAL ASSOCIATION OF WORKING AMERICANS AND NATIONAL ASSOCIATION FOR WORKING AMERICANS; AND ROBERT NEAL POINTER, INDIVIDUALLY AND D/B/A ELECTRONIC BENEFITS GROUP, INC, AND D/B/A AMERICAN BENEFIT PLANS D/B/A ELECTRONIC BENEFITS GROUP, INC; JOSE MICHAEL MANGAWANG, INDIVIDUALLY AND D/B/A NATIONAL ASSOCIATION OF/FOR WORKING AMERICANS, AND D/B/A ENHANCED HEALTH MANAGEMENT AND AMERICAN BENEFIT PLANS; JOHN BAPTIST RAMIREZ A/K/A JOHNNY RHONDO, INDIVIDUALLY AND THE FOUR CORNERS COMPANY, LLC, A/K/A FOUR CORNERS CO., LLC, A/K/A FOUR CORNERS CORP., A/K/A THE 4 CORNERS COMPANY, LLC; AMERICAN ASSOCIATION OF AGRICULTURE, FORESTRY AND FISHING WORKERS; AMERICAN ASSOCIATION OF TRANSPORTATION, COMMUNICATION, ELECTRICAL, GAS AND SANITARY WORKERS;

AMERICAN ASSOCIATION OF WHOLESALE TRADE WORKERS; AMERICAN ASSOCIATION OF MANUFACTURER WORKERS; AMERICAN ASSOCIATION OF SERVICE WORKERS; AMERICAN ASSOCIATION OF CONSTRUCTION WORKERS; AMERICAN ASSOCIATION OF PROFESSIONAL WORKERS;

Defendants, and

[DATE STAMP]
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/s/
DISRICT CLERK
TRAVIS COUNTY, TEXAS

BANK ONE,N.A. – TEXAS; TRIUNE RESOURCES, INC.; TEXAS NATIONAL BANK, N.A. A/K/A FIRST FINANCIAL BANK, COMERICA BANK, TEXAS; WELLS FARGO BANK; BANK ONE, LOUISIANA, A/K/A BANK ONE – LOUISIANA; BANK ONE – BTR; BANK OF AMERICA – TENNESSEE; BANK OF NEW YORK CITY; CITY NATIONAL BANK OF LA; HSBC BANK USA; NATIONAL BANK OF ARKANSAS; REGIONS BANK, LONG ISLAND; COMMERCIAL BANK; BANK OF NEVIS INTERNATIONAL, LTD; AM SOUTH BANK; SOUTH TRUST BANK OF GEORGIA, N.A., A/K/A SOUTHTRUST BANK; COSMOPOLITAN LIFE INSURANCE COMPANY; EQUITY REINSURANCE INTERNATIONAL; BRITANNIA INTERNATIONAL LIFE & CASUALTY, LTD.; CAPITAL REINSURANCE; ELECTRONIC HEALTH PLANS, INC.; PROGRESSIVE ADMINISTRATIVE RESOURCES, INC.; COMPUTER ADMINISTRATIVE INSURANCE SERVICES; ADVANCED ADMINISTRATION, INC.; FIDELITY BENEFIT ADMINISTRATORS; TRIUNE RESOURCES; AND PETRO GENERAL AGENCY, A/K/A PGA MANAGEMENT, INC.

Relief Defendants.

FINAL JUDGMENT, PERMANENT INJUNCTION AND ORDER APPOINTING PERMANENT RECEIVER

The Court, after notice and hearing called this case for trial. When called, the State of Texas appeared by and through its counsel of record Assistant Attorney General Christopher Livingston. Robert Loiseau, Special Deputy Receiver, appeared in person and by and through his counsel of record. Defendants Cross-Claim Plaintiffs John B. Ramirez a/k/a Johnny Rhondo ("Rhondo") and J. Michael Mangawang appeared *pro se*. American Benefit Plans ("ABP"), United Employers Voluntary Employee Beneficiary Association ("UEVEBA"), United Employers Voluntary Employee Beneficiary Association I ("UEVEBA I"), National Association for Working Americans a/k/a National Association of Working Americans ("NAWA"), Electronic Benefits Group,. Inc. ("EBG"), Enhanced Health Managanent ("EHM"), Four Corners Company, LLC a/k/a Four Corners Corp. a/k/a The Four Corners Company, LLC ("Four Corners"), American Association of Agriculture, Forestry, and Fishing Workers, American Association of Transportation, Communication, Electrical, Gas and Sanitary Workers, American Association of Wholesale Trade Workers, American Association of Manufacturer Workers, American Association of Service Workers, American Association of Construction Workers, and American Association of Professional Workers (collectively, the "Default Defendants"),[1] although duly served wholly made default and did not appear and did not file an answer. This Court previously entered an Interlocutory Default Judgment against the Default Defendants. After considering the evidence, the Court finds the State of Texas is entitled to a Final Judgment, Permanent Injunction and Order Appointing Permanent Receiver.

I. FINDINGS

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[1]Rhondo, Mangawang, Robert David Neal, Neal Pointer, and the Default Defendants are hereinafter collectively referred to as the "Defendants."

in the creation of sham trusts in the name of United Employers Voluntary Employee Beneficiary Association ("UEVEBA") and United Employers Voluntary Employee Beneficiary Association I ("UEVEBA I"), into which money from employers, employees, and others were deposited and commingled. Defendants further participated in procuring reinsurance in connection with such health care plans from entities that do not hold certificates of authority to act as an insurer or reinsurer in Texas. The activities described above shall be collectively referred to as the "Unauthorized Health Care Program."

5. Defendants are not authorized or licensed to do insurance business in the State of Texas. None of the Defendants hold certificates of authority as required under Tex. Ins. Code Ann. art. 1.14 § 1 or certificates of authority to establish or maintain a Multiple Employee Welfare Association ("MEWA") as required by Tex. Ins. Code Ann. art. 3.95-2(a) and 28 Tex. Admin. Code § 7.1904. Neither are Defendants qualified as eligible surplus lines insurers under Article 1.14-2 of the Tex. Ins. Code. Despite lacking certificates of authority, the Defendants conducted the unauthorized business of insurance, as that term is defined in Tex. Ins. Code Ann. § 101.051, in violation of Tex. Ins. Code Ann. § 101.102. Persons engaging in the business of insurance without statutory authorization constitute an imminent peril to the public welfare and should be permanently enjoined. Tex. Ins. Code §§ 101.001, 101.103.

6. Defendants' unauthorized business of insurance, if allowed to continue, will be hazardous to the enrollees, beneficiaries, participants, health care providers of the Unauthorized Health Care Program, and to the general public. Unless permanently enjoined, the Defendants will operate in violation of the laws of this State. Such violation of the law of this State has resulted, and will continue to result, in immediate and irreparable injury, loss, and damage. A present and urgent necessity to enjoin Defendants from directly or

indirectly conducting any unauthorized business of insurance exists. Unless Defendants are permanently enjoined, the assets that have been obtained by Defendants in connection with the Unauthorized Health Care Program, including but not limited to contributions made by participating employers and employees for health care benefits, have and will continue to be subjected to illegal preferences that will result in the immediate and irreparable injury of enrollees, beneficiaries, participants, and creditors. Therefore, it is necessary to appoint the Commissioner of Insurance as Permanent Receiver in order to take sole control and possession of the affairs of Defendants' Unauthorized Health Care Program during the pendency of these proceedings to prevent the waste of the assets of the receivership estate, to preserve the *status quo*, and to wind up and liquidate the property and business of Defendants' Unauthorized Health Care Program.

7. A present and urgent necessity to enjoin the Relief Defendants exists to prevent them from transferring any funds or other assets held in the name of, or on behalf of, any or all Defendants that have been obtained in connection with the Unauthorized Health Care Program, or any funds or other assets derived from Defendants' participation in the unauthorized business of insurance in Texas, and from altering, destroying, concealing, or transferring any records or information related to the Unauthorized Health Care Program, and from commencing or prosecuting any action against the Permanent Receiver in connection with or related to the Unauthorized Health Care Program, except as permitted by Tex. Ins. Code Ann. art. 21.28.

8. The Permanent Receiver is vested by operation of law with title to all property and assets of Defendants that have been obtained in connection with the Unauthorized Health Care Program, whether real, personal, or mixed, or whether held in the name of or for the benefit of Defendants, including, but not limited to cash; accounts; stocks; bonds; deposits; funds; trust funds; letters of credit; safe deposit boxes; notes; books; records;

documents; furniture; equipment; real estate; retainages or retainers, and causes of actions and rights of any kind, including, but not limited to, accounts receivables; premiums; and insurance and reinsurance proceeds. Furthermore, the Court finds that the Permanent Receiver succeeds to all rights of Defendants in connection with the Unauthorized Health Care Program, including, but not limited to, the rights of Defendants as customer of any financial institution.

9. Defendants and Relief Defendants were duly and properly served and notified of the trial setting before this Court on May 28, 2002 at 2:00 o'clock p.m., which was set by this Court in its Interim Temporary Injunction and Order Continuing Appointment of Temporary Receiver signed on March 19, 2002 and served on all Defendants and Relief Defendants. The Court finds that the Return of Service for each Defendant has been on file with the Clerk for over ten (10) days as required by Tex. Rules of Civ. Proc.

10. The Cross-Complaint for Violation of Due Process, Interference with An ERISA Fiduciary's Duty, Unlawful Taking, Interference with Interstate Commerce, Diversion and Conversion of ERISA Plan Assets, Reckless Endangerment of an ERISA Plan, Fraud, and Abuse of the Process (the "Cross-Complaint") filed by John B. Ramirez, a/k/a Johnny Rhondo and J. Michael Mangawang is dismissed with prejudice. None of the claims asserted in the Cross-Complaint are supported by the evidence or the law. The State of Texas is authorized, under both federal and state law, to file and prosecute this action to prevent Defendants from conducting the unauthorized business of insurance. No action taken by the State of Texas, the Commissioner of Insurance for the State of Texas, the Special Deputy Receiver, and/or their respective agents, employees, attorneys, and representatives violated the constitutional rights of any Defendant, any Relief Defendant, or any other party affected by, or connected with, the Unauthorized Health Care Program. No action taken by the State of Texas, the Commissioner of Insurance for the

State of Texas, the Special Deputy Receiver, and/or their respective agents, employees, attorney and representatives unlawfully interfered with the duties of any ERISA fiduciary. No action taken by the State of Texas, the Commissioner of Insurance for the State of Texas, the Special Deputy Receiver, and/or their respective agents, employees, attorneys, and representatives unlawfully interfered with interstate commerce. No action taken by the State of Texas, the Commissioner of Insurance for the State of Texas, the Special Deputy Receiver, and/or their respective agents, employees, attorneys, and representatives constitutes unlawful diversion or conversion of assets of an ERISA plan. No action taken by the State of Texas, the Commissioner of Insurance for the State of Texas, the Special Deputy Receiver, and/or their respective agents, employees, attorneys, and representatives constitutes reckless endangerment of an ERISA plan. No action taken by the State of Texas, the Commissioner of Insurance for the State of Texas, the Special Deputy Receiver, and/or their respective agents, employees, attorneys, and representatives constitutes fraud, deceit, or negligent misinterpretation. No action taken by the State of Texas, the Commissioner of Insurance for the State of Texas, the Special Deputy Receiver, and/or their respective agents, employees, attorneys, and representatives constitutes abuse of process or malicious prosecution.

11. The Court finds that Fidelity Benefit Administrators, Inc. ("FBA") received funds in connection with the Unauthorized Health Care Program, including, but not limited to, $1,186,108.88 held in the trust account of the law firm of Katz, Kutter, Alderman, Bryant & Yon, P.A. ("KKABY"). The Court further finds that all such funds, including, but not limited to the $1,186,108.88 held in the trust account of KKABY, constitute property of the receivership estate and that the Permanent Receiver, the Special Deputy Receiver, or their designees are entitled to immediate possession of such funds.

12. The Court finds that Progressive Administration Resources, Inc. ("PAR") received funds in connection with the Unauthorized Health Care Program, including, but not limited to, $389,544.95 held by PAR. The Court further finds that all such funds, including, but not limited to, $389,544.95 held by PAR, constitute property of the receivership estate and that the Permanent Receiver, the Special Deputy Receiver, or their designees are entitled to immediate possession of such funds.

II. PERMANENT INJUNCTION

IT IS THEREFORE ORDERED that the Clerk of this Court issue a writ of injunction against the persons and entities named below enjoining them as follows:

13. Injuction Against Defendants

TO: American Benefit Plans; United Employers Voluntary Employees Beneficiary Association; United Employers Voluntary Employee Beneficiary Association I; National Association for Working Americans, and National Association of Working Americans; Electronic Benefits Group, Inc.; Enhanced Health Management; The Four Corners Company, LLC, a/k/a Four Corners Co., LLC, a/k/a Four Corners Corp., a/k/a The 4 Corners Company, LLC,; ; American Association of Agriculture, Forestry and Fishing Workers; American Association of Transportation, Communication, Electrical, Gas and Sanitary Workers; American Association of Wholesale Trade Workers; American Association of Manufacturer Workers; American Association of Service Workers; American Association of Construction Workers; and American Association of Professional Workers;

(collectively hereinafter referred to as the "Entity Defendants")

and

Robert David Neal, individually and d/b/a American Benefit Plans, United Employers Voluntary Employee Beneficiary Association, United Employers Voluntary Employee Beneficiary Association I, National Association of Working Americans, and National Association for Working Americans; Robert Neal Pointer, individually and d/b/a Electronic Benefits Group, Inc., and d/b/a American Benefit Plans, d/b/a Electronic Benefits Group, Inc.; Jose Michael Mangawang, Individually and d/b/a National Association of/for Working Americans, and d/b/a Enhanced Health Management and American Benefit Plans, and John Baptist Ramirez a/k/a Johnny Rhondo (collectively hereinafter referred to as the "Individual Defendants").

EACH OF YOU are RESTRAINED and ENJOINED from:

(a) advertising, soliciting, offering to sell, or selling any health care plans or insurance products, including, but not limited to, products known or associated with American Benefit Plans, United Employers Voluntary Employee Beneficiary Association, United Employers Voluntary Employee Beneficiary Association I, National Association of Working Americans, Electronic Benefits Group, Enhanced Health Management, or any naming derivative thereof, or any other products consisting in whole or in part of insurance (hereinafter collectively referred to as "unauthorized insurance products");

(b) disseminating information as to coverage or rates of any unauthorized insurance products;

(c) issuing or delivering contracts of unauthorized insurance products;

(d) receiving or collecting any premium, commission, membership fee, enrollee fee, dues, or other consideration for any unauthorized insurance products or any part thereof;

(e) directly or indirectly acting as an agent for or otherwise representing or aiding any Defendant or any other person or insurer in the solicitation, negotiation, procurement or effectuation of any unauthorized insurance products or renewals thereof, including, but not limited to, disseminating information as to coverage or rates, forwarding applications, delivering policies, plans, or contracts, fixing rates or investigating or adjusting claims or losses or in the transaction of matters subsequent to effectuation of the policies, plans or contracts, or in any other manner representing or assisting a person in such transactions;

(f) doing any kind of business recognized as constituting unauthorized insurance within the meaning of the Texas Insurance Code;

(g) doing or proposing to do any business in substance equivalent to any of the foregoing in a manner designated to evade the provisions of the Texas Insurance Code;

(h) doing anything, directly or indirectly, to prevent the Permanent Receiver or his designees from investigating, gaining access to, examining or acquiring any and all records, property or other materials concerning the Entity Defendants and/or the Individual Defendants (in connection with or related to the Unauthorized Health Care

Program), under whatever name they may be found;

(i) disposing of, converting, dissipating, using, releasing, transferring, withdrawing, allowing to be withdrawn, selling, assigning, canceling, hypothecating, offsetting, or concealing in any manner, any property belonging to, payable to, claimed by, or held for the benefit of Defendants in connection with or related to the Unauthorized Health Care Program, whether such property is real, personal, or mixed, including, but not limited to money; accounts; trust accounts; share accounts; stocks; bonds; funds; notes; deposits; letters of credit; safe deposit boxes; furniture; equipment; books; records or documents, or any items into which such property has been transferred, deposited or placed, whether owned or held individually, jointly or severally for Defendants, regardless of the names in which such items are held, except through the authority of the Permanent Receiver or his designees;

(j) releasing, transferring, selling, assigning or asserting ownership of, in any manner, any claims or causes of action belonging to or asserted by the Entity Defendants or the Individual Defendants (to the extent they relate to the Unauthorized Health Care Program), or any claims or causes of action which could be asserted by the Permanent Receiver, including but not limited to any claims or causes of action for premiums; subrogation; insurance and reinsurance proceeds; accounts receivable or debts, except through the authority of the Permanent Receiver or his designees;

(k) removing from the jurisdiction of this Court, or the place of business of Defendants, any property, of any kind or nature, whether real or personal, including, but not limited to, any office equipment, furniture, fixtures, books, and records, and any items that have been acquired, purchased or paid

for by Defendants in connection with the Unauthorized Health Care Program, except through the authority of the Permanent Receiver or his designees;

(l) interfering with these proceedings, or with the lawful acts of the Court's Permanent Receiver or his designees; and

(m) making any claim, charge or offset, or commencing or prosecuting any action, appeal, or arbitration, including administrative proceedings, or obtaining any preference, judgment, attachment, garnishment, or other lien, or making any levy against the Permanent Receiver, or any property claimed by the Permanent Receiver in connection with the Unauthorized Health Care Program, except by doing so in the receivership proceedings herein as permitted by Tex. Ins. Code Ann. art 21.28.

EACH OF YOU ARE FURTHER SPECIFICALLY ORDERED to make available and disclose to the Permanent Receiver, Special Deputy Receiver or their designees, the nature, amount, and location of any and all property of the Entity Defendants, and any and all property received, held or obtained by the Individual Defendants, in connection with the Unauthorized Health Care Program, and immediately surrender that property to the Permanent Receiver, Special Deputy Receiver, or their designees.

14. Injunction against Relief Defendants and Third Parties

TO: Capitol Reinsurance; Electronic Health Plans, Inc; Progressive Administrative Resources, Inc.; Computer Administrative Insurance Services; Advanced Administrators, Inc.; Fidelity Benefit Administrators; Triune Resources; and Petro General Agency a/k/a PGA

Management, Inc.; Bank One, N.A. – Texas; Triune Resources, Inc.; Texas National Bank, N.A. a/k/a First Financial Bank; Comerica Bank, Texas; Wells Fargo Bank; Bank One, Louisiana, a/k/a Bank One – Louisiana; Bank One – BTR; Bank of America – Tennessee; Bank of New York City; City National Bank of LA; HSBC Bank USA; National Bank of Arkansas; Regions Bank; Long Island; Commercial Bank; Bank of Nevis International, Ltd.; AMSouth Bank; South Trust Bank of Georgia, N.A., a/k/a SouthTrust Bank (collectively, the "Relief Defendants"); and those acting in concert with them or on their behalf; and any other banks, savings and loan associations, trust companies, credit unions, brokerage houses, welfare trusts or other financial institutions of any type holding funds that may consist, in whole or in part, of payments received by or on behalf of the Defendants

EACH OF YOU are RESTRAINED and ENJOINED from:

(a) transacting any business on behalf of the Entity Defendants in any manner except through the authority of the Permanent Receiver or his designees;

(b) transacting any business on behalf of the Individual Defendants in connection with or related to the Unauthorized Health Care Program in any manner except through the authority of the Permanent Receiver or his Designees;

(c) doing anything, directly or indirectly, to prevent the Permanent Receiver or his designees from investigating, gaining access to, examining or acquiring any and all records, property or other materials concerning or related to the

Unauthorized Health Care Program, under whatever name they may be found;

(d) disposing of, converting, dissipating, using, releasing, transferring, withdrawing, allowing to be withdrawn, selling, assigning, canceling, hypothecating, offsetting, or concealing, in any manner, any property belonging to, payable to, claimed by, or held for the benefit of Defendants in connection with or related to the Unauthorized Health Care Program, whether such property is real, personal, or mixed, including but not limited to money; accounts; trust accounts; share accounts; stocks; bonds; funds; notes; deposits; letters of credit; safe deposit boxes; furniture; equipment; books; records or documents, or any items into which such property has been transferred, deposited or placed, whether owned or held individually, jointly or severally for Defendants, regardless of the names in which such items are held, except through the authority of the Permanent receiver or his designees;

(e) interfering in any way, with these proceedings or the lawful acts of the Permanent Receiver Special Deputy Receiver or their designees; and

(f) making any claim, charge or offset, or commencing or prosecuting any action, appeal or arbitration, including administrative proceedings, or obtaining any preference, judgment, attachment, garnishment, or other lien, or making any levy or foreclosure against the Permanent Receiver or any property claimed by the Permanent Receiver in connection with the Unauthorized Health Care Program, except in this receivership proceedings as permitted by Tex. Ins. Code Ann. art. 21.28.

EACH OF YOU ARE FURTHER SPECIFICALLY ORDERED to make available, turnover, and disclose to the Permanent Receiver, the Special Deputy Receiver, or their designees the nature, amount, and location of any

and all property related to the Unauthorized Health Care Program or claimed by the Permanent Receiver, including, but not limited to, any of the property listed above, and you are further ordered to immediately surrender all such property to the Permanent Receiver, the Special Deputy Receiver, or their designees. The Court further specifically finds and orders that the Permanent Receiver is vested by operation of law with title to the rights of the Entity Defendants as the customer of any financial institution.

III. APPOINTMENT OF PERMANENT RECEIVER

IT IS FURTHER ORDERED that the Commissioner of Insurance be appointed as Permanent Receiver of the Unauthorized Health Care Program, the Entity Defandants, and of all property received and/or held by the Individual Defendants in connection with the Unauthorized Health Care Program that the Permanent Receiver is granted the following duties and powers:

15. The Permanent Receiver is hereby granted and given all powers and authority under any and all statutes and under the common law of this State authorizing the appointment of a Permanent Receiver, and particularly all of the powers and authority granted in Tex. Ins. Code Ann. arts. 21.28 and Tex. Civ. Prac. & Rem. Code Ann. § 64.001 *et seq.*, and is authorized to conserve, protect, preserve, recover and liquidate any assets, records and property of the Unauthorized Health Care Program and/or the Entity Defendants, including any claims or causes of action, and to take such other necessary action as representative of the Unauthorized Health Care Program and/or the Entity Defendants and the enrollees, beneficiaries, participants, claimants and creditors of the Unauthorized Health Care Program;

16. The Permanent Receiver is authorized to secure and take control possession of all property belonging to the Unauthorized Health Care Program and/or the Entity Defendants, of whatever nature and wherever located, including, but not limited to books,

records, furniture, equipment and other items in the possession of any of the Defendants, and to remove such items from the premises of any of the Defendants.

17. The Permanent Receiver is authorized to conserve, protect, preserve, recover and liquidate any assets, records and property of the Individual Defendants related to the Unauthorized Health Care Program, including any claims or causes of action, and to take such other necessary action as representative of the Individual Defendants in connection with the Unauthorized Health Care Program and the enrollees, beneficiaries, participants, claimants and creditors of the Unauthorized Health Care Program;

18. The Permanent Receiver is authorized to secure and take control and possession of all property belonging to or held by the Individual Defendants, which was obtained in connection with the Unauthorized Health Care Program, of whatever nature and wherever located, including, but not limited to books, records, furniture, equipment and other items in the possession of the Individual Defendants, and to remove such items from the premises of Individual Defendants;

19. The Permanent Receiver is authorized to secure and take control and possession of all assets obtained in connection with or related to the Unauthorized Health Care Program of whatever nature and wherever located including, but not limited to, any and all funds; deposits with banks, savings and loan associations, credit unions and other depositories; contents of safe deposit boxes in the name of or belonging to Defendants; collateral; and any statutory or special deposits made by or for Defendants in connection with the Unauthorized Health Care Program with any officer or agency of any State or the federal government.

20. The Permanent Receiver is authorized to receive, collect, control, open and review all mail addressed in any manner to any of the Defendants,

arriving at the address of any of the Defendants, or intended for any of the Defendants;

21. The Permanent Receiver is authorized to take action as he deems necessary to protect enrollees, beneficiaries, and other participants of the Unauthorized Health Care Program, including but not limited to paying benefits, at his discretion;

22. The Permanent Receiver is authorized to liquidate the Unauthorized Health Care Program, the Entity Defendants, and/or any the property obtained or held by the Individual Defendants in connection with or through the Unauthorized Health Care Program; terminate the operations of the Unauthorized Health Care Program; cancel plans or contracts for benefits, and enter into any agreements for the transfer of plans or contracts issued by any of the Defendants, as he deems appropriate, in order to wind up the affairs of the Unauthorized Health Care Program and/or the Entity Defendants;

23. The Permanent Receiver is authorized to administer the operations of the Unauthorized Health Care Program, the Entity Defendants, and/or the Invidual Defendants (to the extent such operations relate to the Unauthorized Health Care Program); to order to wind up and terminate the affairs of the Unauthorized Health Care Program and the Entity Defendants to cancel or ratify existing contracts, at his discretion; to enter into any contracts necessary to perform his duties; to employ and pay any legal counsel, accountants, third-party administrators, clerks and such assistants as he deems necessary; and to pay the administrative expenses of the receivership estate out of the funds or assets of the receivership estate as he deems appropriate;

24. The Permanent Receiver is authorized to supervise, suspend, terminate, or dismiss, at his discretion, any or all agents, employees, officers , and directors of Defendants in connection with the Unauthorized Health Care Program, or, at his discretion,

to retain any or all necessary employees and agents and compensate them as he deems necessary from the funds of the receivership estate;

25. The Permanent Receiver is authorized to exclude any and all persons from the premises of the Unauthorized Health Care Program, the Entity Defendants, and/or any premises from which any of the Defendants was operating the Unauthorized Health Care Program, including but not limited to Defendants and Defendants' agents, employees, officers and directors, at the Permanent Receiver's sole discretion.

26. The Permanent Receiver is authorized to continue the operation of any bank accounts of the Unauthorized Health Care Program, the Entity Defendants, and/or any bank accounts of the Individual Defendants related to the Unauthorized Health Care Program, or to close such accounts, at the Permanent Receiver's sole discretion; and

27. The Permanent Receiver is authorized to file, prosecute and defend or settle any suit or suits heretofore filed or which may hereafter be filed in connection with the Unauthorized Health Care Program deemed by said Permanent Receiver to be necessary to protect any of the interested parties or any affected thereby, and to preserve the value of all property and assets of the receivership estate and its creditors.

28. The Permanent Receiver is authorized to take any other action, at its discretion, to enforce the provisions of this Final Judgment, Permanent Injunction and Order Appointing Permanent Receiver.

29. The Permanent Receiver is authorized and directed to recover any commissions, agent fees, administrative costs or charges or any other deduction from the funds contributed by the employers, the employee plans, the employers and/or the beneficiaries by any Defendants or Relief Defendants.

IT IS FURTHER ORDERED that, under Tex. Ins. Code Ann. art. 21.28 § 2(b), all property belonging to or held by the Unauthorized Health Care Program, the Entity Defendants, and/or any property belonging to or held by the Individual Defendants that was obtained in connection with the Unauthorized Health Care Program, including but not limited to those assets described in the Permanent Injunction and any and all proceeds from that property, are placed in *custodia legis* and title to such property is vested in the Permanent Receiver.

IT IS FURTHER ORDERED that in the event that a successor Commissioner of Insurance is appointed, the successor shall become the Permanent Receiver upon his appointment, and the former Commissioner of Insurance shall be discharged as Permanent Receiver.

The Court finds that the Commissioner of Insurance has designated Robert Loiseau to serve as Special Deputy Receiver. The Special Deputy Receiver, and the designated representatives of the Permanent Receiver and Special Deputy Receiver, have all the rights and powers of the Permanent Receiver under this Permanent Injunction and Order Appointing Permanent Receiver, subject to any limitations imposed by the Permanent Receiver.

IV. OTHER ORDERS

IT IS FURTHER ORDERED that anyone over the age of 18 who is not a party to nor interested in the outcome of this suit may serve all citations, writs and notices in this cause.

IT IS FURTHER ORDERED that the Defendants and Relief Defendants, their officer, agents, servants, employees, and attorneys; and those persons in active concert or participation with them who receive actual notice of this order by personal service or otherwise; are commanded forthwith to desist and refrain from, directly or indirectly, aiding Defendants in engaging in the

business of insurance as that term is defined in the Texas Insurance Code.

IT IS FURTHER ORDERED that no bond is required of the State of Texas, Texas Department of Insurance, Commissioner of Insurance, or the Permanent Receiver, and the Special Deputy Receiver.

IT IS FURTHER ORDERED that the Texas Department of Insurance is awarded $74,192.54 as reasonable and necessary investigation fees from the Defendants (jointly and severally), but not to the Relief Defendants, pursuant to Tex. Civ. Prac. & Rem. Code Ann. §§ 64.051 and 402.006.

IT IS FURTHER ORDERED that the State of Texas is awarded civil penalties in the amount of $4,150,000.00 from the Defendants (jointly and severally), but not the Relief Defendants, pursuant to Tex. Ins. Code Ann. § 101.105

IT IS FURTHER ORDERED that John B. Ramirez a/k/a Johnny Rhondo and J. Michael Mangawang take nothing by way of the claims they asserted against the State of Texas, the Texas Department of Insurance, the Commissioner of Insurance, and the Special Deputy Receiver in this case.

IT IS FURTHER ORDERED that all costs of Court are taxed against Defendants, jointly and severally, but not the Relief Defendants.

SIGNED this 28th day of May, 2002.

/s/
PRESIDING DISTRICT COURT JUDGE

EXHIBIT A - 4

NO. GV2-00903

STATE OF TEXAS,	IN THE DISTRICT COURT OF
vs.	TRAVIS COUNTY, TEXAS
AMERICAN BENEFIT PLANS, et al.	53RD JUDICIAL DISTRICT COURT

FINDINGS OF FACT AND CONCLUSIONS OF LAW

In response to a request from Defendant Robert Neal Pointer, the Court makes and files the following original findings of fact and conclusions of law in accordance with Texas Rules of Civil Procedure 296 and 297.

I. FINDINGS OF FACT

1. Robert David Neal is a resident of Texas. See Exhibit 67.

2. Neal David Pointer is a resident of Texas. See Exhibit 52.

3. John B. Ramirez is a resident of California and sometimes goes under the name "Johnny Rhondo." See Tr.[1] at 46; First Amended Cross-Complaint (p. 1); Exhibits 66, 85, 94 (p.24); Exhibit 95 (p.21).

4. Jose Michael Mangawang is a resident of California. See Tr. at 46; First Amended Cross-Complaint (p.1); Exhibit 94 (p.24); Exhibit 95 (p.21).

5. Robert David Neal; Neal Pointer; John B. Ramirez; Jose Michael Mangawang; American Benefit Plans ("ABP"); the National Association for Working Americans ("NAWA"); Electronic Benefits Group, Inc. ("EBG") United Employers Voluntary Employees Beneficiary Association ("UEVEBA"); the United Employers Voluntary Employees Beneficiary Association

I ("UEVEBA 1"); the Four Corners Company, LLC ("Four Corners"); Enhanced Health Management, Inc. ("EHM"); the American Association of Agriculture, Forestry and Fishing Workers, American Association of Transportation, Communication, Electrical, Gas and Sanitary Workers, American Association of Wholesale Trade Workers, American Association of Manufacturer Workers, American Association of Service Workers, American Association of Construction Workers, and American Association of Professional Workers (the "Associations") (collectively, the "Defendants") worked together to offer health care benefits programs (the "Unauthorized Health Care Programs") to employers in Texas and across the country. See e.g. Tr. at 44, 66, 108, 113, 120, 122-123; Exhibits 13, 24-26, 33, 38, 49, 53-55, 62-65, 69, 82, 85, 86, 94 (pp.2-3, 14-15, 21, 24), 95 (pp.12-13), 100, 106, 135, 137, 183, 185, 191, 197, and 215.

6. The Defendants began conducting the Unauthorized Health Care Programs no later than January 1, 2001, and continued until at least March 6, 2002. See Tr. at 105; Exhibits 12, 29, 41, 45, 60, 61,164 (pp. 75-76), 216, 232.

7. The Unauthorized Health Care Programs offered by the Defendants purported to provide indemnification or expense reimbursement for medical expenses either by direct payment, reimbursement, or otherwise to persons in Texas for health care provided in Texas to Texans. See e.g. Tr. at 44, 66, 108, 113, 120, 122-123; Exhibits 13, 24-26, 33, 38, 49, 53-55, 62-65, 69, 82, 85, 86, 94 (pp.2-3, 14-15, 21, 24), 95 (pp.12-13), 100, 106, 135, 137, 183, 185, 191, 197, and 215.

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[1] The abbreviation "Tr." will be used to refer to the Transcript of the hearing regarding the permanent injunction, held on May 28, 2002.

8. ABP, NAWA, and EBG were all based in, and operated from, Texas. See Exhibits 21, 43, 48, 50, 52, 146, 187, 223, 227, and 229.

9. Robert David Neal operated ABP, NAWA , and EBG. See Exhibits 10, 16, 18,20, 23, 30, 31, 32, 38, 39, 40, 41, 42, 43, 44, 47, 51, 53, 54, 67, 85, 86, 94, 99, 133, 134, 135, 145, 159, 183, 185, 191, 200, 202, 203, 205, 214, 216, 217, 222, 225 (pp.1-2, 6, 9), 95 (pp. 43, 47-48).

10. Neal Pointer aided in the operation of ABP and NAWA, and the creation of EBG. See Exhibits 21,43,48, 50, 52, 146, 187, 223, 227, and 229.

11. Neal Pointer participated in the operation of ABP, NAWA, EBG, UEVEBA and UEVEBA I. See Exhibits 21, 43, 48, 50, 52, 146, 187, 223, 227, 229.

12. John B. Ramirez operated UEVEBA and UEVEBA I. See Tr. At 31; First Amended Cross-Complaint at 2; Exhibits 41, 53, 54, 55, 56, 57, 66, 83, 85, 94, 105, 136, 141 (p.24), 95 (pp.14-15), 189.

13. John B. Ramirez operated Four Corners. See 56, 57, 98, 105.

14. Jose Michael Mangawang aided in the operation of UBVEBA and UEVEBA I. See Tr. At 31; First Amended Cross-Complaint at 2; Exhibits 55, 94 (p.24), 95 (p.14-15), 141,214.

15. Jose Michael Mangawang operated EHM. See Exhibit 95 (p.33), 98, 141.

16. UEVEBA and UEVEBA I maintained offices and bank accounts in Texas. See Exhibits 62, 63, 64, 65, 132, 138, 139, 143, 206, 224, 228.

17. Robert David Neal, Neal Pointer, John B. Ramirez, Jose Michael Mangawang, Four Comers, and EHM all participated in the operation of UEVEBA and

UEVEBA I. See Exhibits 83, 95 (pp.33, 35), 98, 105, 132, 136, 138, 139, 141, 143, 182, 206, 224, 228.

18. John B. Ramirez and Jose Michael Mangawang operated the Associations in conjunction with UEVEBA and UEVEBA I. See Exhibits 41, 55.

19. UEVEBA and UEVEBA I appointed Robert David Neal as their agent. See Exhibit 41, 62-65, 132, 139, 143, 182, 206, 224, 228.

20.The Associations appointed Robert David Neal as their agent. See Exhibit 41.

21. Numerous employers in Texas contracted with ABP, NAWA, UEVEBA, UEVEBA I, Four Corners, and/or John B. Ramirez to create and operate health benefit plans for their employees. See Exhibits 13, 24, 25, 26, 49, 69-82, 96, 100, 106-131.

22. UEVEBA, UEVEBA I, Four Corners, and John B. Ramirez contracted with Texas residents to provide services for those residents in Texas. See Exhibits 13, 24, 25, 26, 49, 69-82, 96, 100, 106-131.

23. UEVEBA and UEVEBA I employed Jose Michael Mangawang and EHM to monitor their operations in providing services to all of the various employers who had purchased services from them. See Exhibits 53, 54, 55, 83, 85, 94 (p.24), 95 (pp. 14-15), 105, 136, 214.

24. The Defendants associated numerous "third party administrators, "including, but not limited to, Progressive Administration Resources, Inc. ("PAR"), Fidelity Benefits Administration, Inc. ("FBA"), and Advanced Administration, Inc. ("AAI"), (collectively, the "TPAs") to aid in the administration of the Unauthorized Health Care Programs. See e.g. Exhibits 65, 86, 94 (pp.5-6), 132, 133, 137.

25. Employers and/or their employees paid substantial sums of money to the Defendants, through the TPAs, as contributions intended to provide health care benefits to the employers' employees under the Unauthorized Health Care Programs. See e.g. Tr. 114-115; Exhibits 37, 89, 91, 94 pp 5-6, 14-17, 21-23), 95 (p.37), 101-104, 135, 161-163,174-176, 191, 230.

26. The TPAs would collect the contributions, pay various expenses (including their own fees and agents' commissions), and, in certain instances, forward the remainder to the Defendants. See e.g. Tr. at 114-115; Exhibits 26, 93, 118, 146 (pp.14-17, 21-23), 147 (p.37), 188, 191, 193.

27. The Defendants pooled and commingled the contributions made by the various employers and their employees, both at the TPAs as well as after the remaining funds were forwarded to them from the TPAs. See e.g. Tr. at 106, 124; Exhibits 94 p. 35), 95 (pp.14-19, 25, 34).

28. The Defendants purported to purchase insurance and/or coverage for the enrollees as a group, rather than for each individual employer or employer's plan. See e.g. Exhibits 62-64, 94 (p.34).

29. Few, if any, of the claims submitted by enrollees allegedly covered under the Unauthorized Health Care Programs have been paid. See e.g. Tr. at 43, 49, 55, 67, 68.

30. The insurance and/or reinsurance purportedly purchased by the Defendants paid few, if any, claims submitted by enrollees covered by the plans sold by the Defendants. See Tr. at 67, 68.

31. The Defendants failed to keep adequate accounting records to accurately determine the identity of the employers, the enrollees, or the claims that were part of the Unauthorized Health Care Programs. See e.g. Tr. at 67, 84, 88-92.

32. The Defendants failed to keep adequate accounting records to determine the amounts they had collected from the employers and/or enrollees pursuant to the Unauthorized Health Care Programs. See e.g. Tr. at 67, 84, 88-92.

33. The Defendants diverted funds intended to pay claims to other purposes. See Tr. at 88-92, 94-95; Exhibits 21, 29, 30, 31, 32, 46, 84, 139, 159, 166, 192, 193, 196, 200, 206, 227-230.

34. Large sums collected under the Unauthorized Health Care Plans were paid to the First American Christian Society ("FACS") and/or to Charles Walker to purportedly purchase control of FACS for the Neal family. See e.g. Tr. at 88-92, 94-95;Exhibits 30-32, 166, 192, 193, 196, 200-206.

35. None of the Defendants hold certificates of authority as required under Tex. Ins. Code. Ann. art. 1.14 § I or certificates of authority to establish or maintain a Multiple Employee Welfare Association ("MEWA") as required by Tex. Ins. Code Ann. art. 3.95-2(a) and 28 Tex. Admin. Code § 7.1904. See Exhibits 147-154, 159.

36. None of the Defendants qualified as eligible surplus lines insurers under Tex. Ins. Code art. 1.14-2. See Exhibits 147-154, 159.

37. The Defendants were engaged in the unauthorized business of insurance as that term is defined in the Texas Insurance Code. See Tr. at 44, 66, 108, 113, 120, 122-123; Exhibits 33, 38, 49, 53-55, 62-65, 69, 82, 85, 86, 94 (pp. 2-3, 14-15, 21, 24), 95 (pp. 12-13), 100, 106, 135, 137, 183, 185, 191, 197, and 215.

38. The Defendants agreed to conduct the Unauthorized Health Care Programs, and worked with one another in the operation of the Unauthorized Health Care Programs. See Tr. at 66, 08, 113, 120, 122-123; Exhibits 33, 38, 49, 53-55, 62-65, 69, 82, 85, 86, 94 (pp.2-

3, 14-15, 21, 24), 95 (pp.12-13), 100, 106-135, 137, 183, 185, 191, 197, and 215.

39. Several states, including Arkansas, Louisiana, and Colorado, issued cease and desist orders requiring the Defendants to stop engaging in the business of insurance. See Tr. at 53; Exhibits 53, 54, 85.

40. In spite of the cease and desist orders, the Defendants continued marketing and operating the Unauthorized Health Care Programs at least until March 6, 2002, when they were placed into temporary receivership. See Tr. at 46-47.

41. After March 6,2002, the Defendants continued to refuse to comply with the orders and directives of the Texas Department of Insurance, and refused to comply with the orders of the receivership court. See Tr. at 46, 48.

42. The continued operation of the Unauthorized Health Care Programs is hazardous to the public, to the employers and employees to whom the Defendants sold the programs, and to health care providers who provide services to enrollees under the Unauthorized Health Care Programs. See e.g. Tr. at 43, 49, 55, 67, 68, 84, 88-92, 94-95; Exhibits 21, 29, 30-32, 46, 84, 139, 159, 166, 192, 193, 196, 200-206, 227-230.

43. A permanent receiver should be appointed to take control of ABP, NAWA, UEVEBA, UEVEBA I, the Associations, EBG, EHM, and Four Corners. See Tr. at 88-92,94-95; Exhibits 30-32, 166, 192, 193, 196, 200-206.

44. The State of Texas incurred $74,192.54 in reasonable and necessary expenses and costs in investigating the improper and illegal activities of the Defendants. See Tr. at 97-98.

45. The Defendants conducted at least 415 separate actions constituting the illegal and unauthorized business of insurance over at least 415 days. See Tr. at

44, 66, 105, 108, 113, 120, 122-123, Exhibits 33, 38, 49, 53-55, 62-65, 69, 82, 85, 86, 94 (pp.2-3, 14-15, 21, 24), 95 (pp. 12-13), 100, 106-135, 137, 183, 185, 191, 197, and 215.

46. The May 28, 2002 trial of this matter was set in the Interim Temporary Injunction and Order Continuing Appointment of Temporary Receiver entered on March 19, 2002. See Exhibit 160.

47. The Defendants and Relief Defendants were duly and properly served and notified of the trial setting. See Exhibit 160.

48. No objections were made when this case was called for trial on the merits. See Tr. at 24.

49. Before calling the case for trial on the merits, an Interlocutory Default Judgment was entered against the following entities: American Benefit Plans; United Employers Voluntary Employee Beneficiary Association; United Employers Voluntary Employee Beneficiary Association I; National Association for Working Americans; National Association of Working Americans; Electronic Benefits Group, Inc.; the Four Corners Company; a/k/a Four Corners Co., LLC; a/k/a Four Corners Corp.; a/k/a The Four Corners Company, LLC; American Association of Agriculture, Forestry and Fishing Workers; American Association of Transportation, Communication, Electrical, Gas and Sanitary Workers; American Association of Wholesale Tradeworkers; American Association of Manufacturer Workers; American Association of Service Workers; American Association of Construction Workers; and American Association of Professional Workers.

50. Defendant Neil Pointer, although having filed an Original Answer in this cause, failed to appear in person or by counsel when the case was called for trial.

51. Defendant Robert David Neal filed an Original Answer by and through his counsel of record.

52. When called for trial, Robert David Neal appeared in the courtroom, but neither he, nor his counsel, made any announcement.

53. At no time during the trial of the case did Robert David Neal or his counsel make any objections to any of the evidence, the testimony, or the rulings of the Court, although Mr. Neal was present in the courtroom.

54. Prior to calling the case for trial on the merits, the Court granted the Motion for Severance filed by the Special Deputy Receiver and severed the claims by and between the State of Texas and the Special Deputy Receiver on the one hand, and Cosmopolitan Life Insurance Company, Equity Reinsurance International, Capital Reinsurance Company, and Britannia International Life & Casualty, Ltd., on the other hand, into a separate lawsuit.

55. The Return of Service for each Defendant was on file with the Clerk for over ten (10) days prior to trial.

56. No party filed a motion for continuance or requested a continuance of the trial setting.

57. No party filed or made any objection to the State of Texas' seeking an award of civil penalties or an award of costs.

58. John B. Ramirez, Jose Michael Mangawang, and Robert David Neal attended the trial. See Tr. at 23, 144-145.

59. John B. Ramirez and Jose Michael Mangawang appeared on their own behalf, cross-examined witnesses presented by the State of Texas, and presented evidence and argument in opposition to the relief sought by the State of Texas. See Tr. at 23, 29- 33, 52-68, 75-84, 93, 98-100, 104-130, 138-141.

60. None of the Defendants filed any special appearance or other objection to the exercise, by this Court, of *in personam* jurisdiction over them.

61. Progressive Administration Resources, Inc. ("PAR") was a third party administrator for the Unauthorized Health Care Plans. See Tr. at 91-92; Exhibit 137.

62. PAR received funds from employers who had been sold health care programs by the Defendants. See Tr. at 91-92.

63. As of the date of trial, PAR held $389,544.95 traceable to the illegal health care scheme that is the subject of this action. See Tr. at 92.

64. Fidelity Benefits Administration, Inc. ("FBA") was a third party administrator for the Defendants' health care scheme. See Tr. at 91; Exhibits 61-132.

65. FBA received funds from employers who had been sold health care programs by the Defendants. See 91

66. As of the date of trial, FBA holds at least $$1,186,108.88 traceable to the illegal health care scheme that is the subject of this action. See Tr. at 91.

67. The funds held by FBA are in the trust account of its attorneys, Katz, Kutter, Alderman, Bryant & Yon, PA. ("KKABY"). See Tr. at 91.

68. The United States Department of Labor determined that the Defendants' operations constituted a "multiple employer welfare arrangement under 29 U.S.C. §1002(40), and that the Defendants were, therefor, subject to state law insurance regulations. See Exhibits 220-221.

69. Defendants Rhondo and Mangawang removed this action to Federal District Court claiming that federal law preempted the State of Texas' action against them

and the other Defendants. On May 22, 2002, Federal District Judge Sam Sparks entered an Order of Remand sending this action back to State District Court. In his Order, Judge Sparks ruled that federal law did not preempt the claims asserted in this action by the State of Texas and further held "in light of the substantial State interest in the regulation of unauthorized business of insurance, the Court agrees that *Burford* abstention is appropriate and is an alternative ground for remand of this cause." See Exhibit 236, p. 5.

70. Defendants Rhondo and Mangawang filed a cross action against Robert Loiseau, the Special Deputy Receiver and the State of Texas.

71. On May 24, 2002, the State of Texas filed a General Denial to the Cross-Complaint filed by Rhondo and Mangawang.

72. On May 24, 2002, the Special Deputy Receiver filed his Original Answer to the Cross-Complaint of Rhondo and Mangawang.

73. On May 24, 2002, the Special Deputy Receiver filed his Notice of Remand with the District Court and served all parties and counsel of record.

74. Robert Loiseau is the individual designated by the Texas Commissioner of Insurance as the Special Deputy Receiver for the entities placed into receivership in this action. See Tr. at 42; Exhibit 1.

75. The State of Texas and Mr. Robert Loiseau, as well as their agents and employees, acted in accordance with federal and Texas law in taking the actions they did in relation to the Unauthorized Health Care Plans. See Tr. at 69.

76. Three separate hearings were held in which the Defendants had the opportunity to present evidence and cross-examine witnesses in defending themselves against the allegations made by the State of Texas.

77. The Defendants' right to due process of law was not violated by the actions taken by the State of Texas, Robert Loiseau, the Special Deputy Receiver for American Benefits Plans, et al., and/or by this Court.

78. The Defendants failed to produce any evidence that any of their constitutional rights had been violated by the State of Texas, by Robert Loiseau, the Special Deputy Receiver for American Benefits Plans, et al., or any of the agents, employees, or attorneys of the State of Texas or of Robert Loiseau, the Special Deputy Receiver for American Benefits Plans, et al.

79. The Defendants failed to produce any evidence of wrongdoing of any kind by the State of Texas, by Robert Loiseau, the Special Deputy Receiver for American Benefits Plans, et al., or any of the agents, employees, or attorneys of the State of Texas or of Robert Loiseau, the Special Deputy Receiver for American Benefits Plans, et al.

II. CONCLUSIONS OF LAW

80. A person or entity may not directly or indirectly do an act that constitutes the business of insurance except as authorized by statute. See Tex. Ins. Code §101.102(a).

81. The following acts constitute the business of insurance:

> (1) making or proposing to make, as an insurer, an insurance contract;
>
> (2) taking or receiving an insurance application;
>
> (3) receiving or collecting any consideration for insurance, including:

(a) a premium;
(b) a commission;
(c) a membership fee;
(d) an assessment; or
(e) dues;

(4) issuing or delivering an insurance contract to a resident of Texas or to a person authorized to do business in Texas;

(5) directly or indirectly acting as an agent for or otherwise representing or assisting an insurer or person in;

(a) soliciting, negotiating, procuring, or effectuating insurance or a renewal of insurance;
(b) disseminating information relating to coverage or rates;
(c) forwarding an insurance application;
(d) delivering an insurance policy or contract;
(e) inspecting a risk;
(f) setting a rate;
(g) investigating or adjusting a claim or loss;
(h) transacting a matter after the effectuation of the contract that arises out of the contract; or
(i) representing or assisting an insurer or person in any other manner in the transaction of insurance with respect to a subject of insurance that is resident, located, or to be performed in this state;

(6) contracting to provide in this state indemnification or expense reimbursement for a medical expense by direct payment, reimbursement, or otherwise to a person

> domiciled in this state or for a risk located in this state, whether as an insurer, agent, administrator, trust, or funding mechanism or by another method;
>
> (7) doing any kind of insurance business specifically recognized as constituting insurance business within the meaning of statute relating to insurance;
>
> (8) doing or proposing to do any insurance business that is in substance equivalent to conduct described by Subdivisions (1)-(8) in a manner designed to evade statutes relating to insurance; or
>
> (9) any other transaction of business in this state by an insurer.

See Tex. Ins. Code § 101.051.

82. Actions described in Tex. Ins. Code § 101.051 as constituting the business of insurance, if taken by an unlicensed or unauthorized person or insurer, and that occur in Texas and affect a person in another state or jurisdiction, constitute the business of insurance in Texas. See Tex. Ins. Code § 101.051.

83. Persons engaging in the business of insurance without statutory authorization constitute an imminent peril to the public welfare and should be permanently enjoined. Tex. Ins. Code §§ 101.001; 101.103; 101.105.

84. A person or entity that engages in the unauthorized business of insurance is subject to a civil penalty of not more than $10,000.00 for each violation and for each day of violation. See Tex. Ins. Code §101.105.

85. The Defendants were engaged in the unauthorized business of insurance in the State of Texas.

86. The Defendants are subject to the in personam jurisdiction of the courts of the State of Texas.

87. This lawsuit is within the subject matter jurisdiction of the courts of the State of Texas.

88. The Defendants have conducted business in the State of Texas by contracting with individuals and/or entities in the State of Texas for services to be rendered in the State of Texas and by establishing bank accounts in the State of Texas in order to do business in the State of Texas.

89. The contacts of the Defendants with the State of Texas are specifically related to, and give rise to, the claims asserted in this suit.

90. The contacts of the Defendants are systematic and continuous in that they have either been based in Texas, or have systematically sought to do business with Texas residents.

91. The contacts of the Defendants with the State of Texas are systematic and continuous based upon their establishment of bank accounts in Texas and their appointment of individuals in Texas as agents to conduct business in the State of Texas.

92. The Defendants agreed among themselves to offer and operate the illegal and unauthorized insurance business that is the subject of this action.

93. The Defendants intended to engage in the unauthorized business of insurance.

94. The Defendants diverted funds collected from employers and/or enrollees of the Unauthorized Health Care Programs, and intended to pay claims of and/or to purchase insurance coverage for the enrollees, to other purposes.

95. The Defendants' unauthorized business of insurance, if allowed to continue, will be hazardous to the enrollees, beneficiaries, participants, health care providers of the Unauthorized Health Care Program, and to the general public.

96. Unless permanently enjoined, the Defendants will continue to operate in violation of the laws of this State.

97. Unless the Defendants are permanently enjoined, the assets that have been obtained by the Defendants in connection with the Unauthorized Health Care Program, including but not limited to contributions made by participating employers and employees for health care benefits, have and will continue to be subjected to illegal preferences that will result in the immediately and irreparably injury of enrollees, beneficiaries, participants, and creditors.

98. The Permanent Receiver is vested by operation of law with title to all property and assets of the Defendants that have been obtained in connection with the Unauthorized Health Care Program, whether real, personal, or mixed, or whether held in the name of or for the benefit of Defendants, including, but not limited to cash; accounts; stocks; bonds; deposits; funds; trust funds; letters of credit; safe deposit boxes; notes; books; records; documents; furniture; equipment; real estate; retainages or retainers, and causes of actions and rights of any kind, including, but not limited to, accounts receivables; premiums; and insurance and reinsurance proceeds.

99. The Permanent Receiver succeeds to all rights of the Defendants in connection with the Unauthorized Health Care Program, including, but not limited to, the rights of the Defendants as customer of any financial institution.

100. All claims asserted in the Cross-Complaint for Violation of Due Process, Interference with An ERISA Fiduciary's Duty, Unlawful Taking, Interference with

Interstate Commerce, Diversion and Conversion of ERISA Plan Assets, Reckless Endangerment of an ERISA Plan, Fraud, and Abuse of Process (the "Cross-Complaint") filed by John B. Ramirez, a/k/a Johnny Rhondo and J. Michael Mangawang are dismissed with prejudice.

101. None of the claims asserted in the Cross-Complaint are supported by the evidence or the law.

102. The State of Texas is authorized, under both federal and state law, to file and prosecute this action to prevent Defendants from conducting the unauthorized business of insurance.

103. No action taken by the State of Texas, the Commissioner of Insurance for the State of Texas, the Special Deputy Receiver, and/or their respective agents, employees, attorneys, and representatives violated the constitutional rights of any Defendant, any Relief Defendant, or any other party affected by, or connected with, the Unauthorized Health Care Program.

104. No action taken by the State of Texas, the Commissioner of Insurance for the State of Texas, the Special Deputy Receiver, and/or their respective agents, employees, attorneys, and representatives unlawfully interfered with the duties of any ERISA fiduciary.

105. No action taken by the State of Texas, the Commissioner of Insurance for the State of Texas, the Special Deputy Receiver, and/or their respective agents, employees, attorneys, and representatives unlawfully interfered with interstate commerce.

106. No action taken by the State of Texas, the Commissioner of Insurance for the State of Texas, the Special Deputy Receiver, and/or their respective agents, employees, attorneys, and representatives constitutes unlawful diversion or conversion of assets of an ERISA plan.

107. No action taken by the State of Texas, the Commissioner of Insurance for the State of Texas, the Special Deputy Receiver, and/or their respective agents, employees, attorneys, and representatives constitutes reckless endangerment of an ERISA plan.

108. No action taken by the State of Texas, the Commissioner of Insurance for the State of Texas, the Special Deputy Receiver, and/or their respective agents, employees, attorneys, and representatives constitutes fraud, deceit, or negligent misrepresentation.

109. No action taken by the State of Texas, the Commissioner of Insurance for the State of Texas, the Special Deputy Receiver, and/or their respective agents, employees, attorneys, and representatives constitutes abuse of process or malicious prosecution.

110. The permanent receiver and the special deputy receiver are entitled to immediate possession of all funds in the hands of PAR, FBA, and/or KKABY that are traceable to the Unauthorized Health Care Plans.

111. The Defendants are liable, jointly and severally, for the $74,192.54 in reasonable and necessary costs incurred by the State of Texas in investigating their illegal activities.

112. The Defendants are liable, jointly and severally, for civil penalties in the amount of $4,150,000.00.

113. In 1983, the United States' Congress amended ERISA specifically to clarify that states could regulate multiple employer welfare associations ("MEWAs"). See Atlantic Healthcare Benefits Trust v. Googins, 2 F.3d 1, 5 (2nd Cir. 1993); see also Fuller v Norton, 86 F.3d 1016, 1023-4 (10th Cir. 1996) (citing the congressional record and noting that "the impetus behind the ..[1983].. amendment was an interest in curbing abuses by multiple employer trusts, which would claim

ERISA preemption when states attempted to regulate them").

114. The amendment granted states broad authority to regulate MEWAs as insurance companies. See Fuller, 86 F.3d at 1023; Googins, 2 F.3d at 5 (citing Atlantic Healthcare Benefits Trust v. Foster, 809 F.Supp. 365 (M.D. Pa. 1992)).

115. This amendment sought to curb what had become an epidemic of abuse of the ERISA preemption provision by those peddling illegal and/or insolvent insurance schemes such as the ones at issue in this case. See Atlantic Healthcare Benefits Trust v. Googins, 2 F.3d 1, 5 (2nd Cir. 1993); see also Fuller v Norton, 86 F.3d 1016, 1023-4 (10th Cir. 1996)(citing the congressional record and noting that "the impetus behind the [1983].. amendment was an interest in curbing abuses by multiple employer trusts, which would claim ERISA preemption when states attempted to regulate them").

116. Regulatory requirements imposed by the State of Texas, such as licensing and financial requirements, are allowed under ERISA. See Googins, 1 F.3d at 5-6 (licensing requirements); Fuller, 86 F.3d at 1026 see also Atlantic Health Care Benefits Trust v. Foster, 809 F.Supp. 365, 374 (M.D. Penn. 1992); MDPhysicians & Assoc., Inc. v.Wrotenbery, 762 F.Supp. 695, 699 (N.D. Tex. 1991), aff'd, 957 F.2d 178 (5th Cir. 1992) (state law licensing regulations apply to MEWAs).

117. A "MEWA" is an employee welfare benefit plan, or any other arrangement (other than an employee welfare benefit plan), which is established or maintained for the purpose of offering or providing any benefit described in 29 U.S.C. § 1002(1), including medical benefits, to the employees of two or more employers. See 29 U.S.C. § 1002(40).

118. The Defendants' operations form a MEWA as that term is defined under 29 U.S.C. § 1002(40).

119. The Defendants and their Unauthorized Health Care Plans are not exempt from state law insurance regulations.

120. Texas insurance laws and regulations, as applied to the Defendants and their Unauthorized Health Care Plans, are not pre-empted by federal law.

121. Judge Cooper's March 19, 2002 Order provided that "The Permanent Injunction is hereby set for hearing before the District Court on May 28, 2002 at 2:00 o'clock p.m." It is axiomatic that a trial on a permanent injunction is a full trial of all issues in the case. *Elizondo v. Williams,* 643 S.W. 2d 765, 767 (Tex. App.-San Antonio 1982, no writ.); 44 Tex. Jur.3d *Injunctions, Section 14, citing Ex Parte Zuccaro,* 106 Tex. 197, 163 SW. 579 (1914).

122. Rule 683 requires an Order granting a Temporary Injunction set the cause for trial on the merits. Tex. Rules of Civil Procedure 683.

123. Texas is a "Fair Notice Pleading" state. *Horizon/CMSHealthcare Corp. v. Auld,* 34 S.W. 2d 887, 896 (Tex. 2000).

124. A general prayer for relief supports any relief raised by the evidence so long as there are sufficient allegations to give fair notice of the claim. *Stoner* v. *Thompson,* 578 S.W. 2d 679, 683 (Tex. 1979); *Holmstrum v. Lee,* 26 S.W. 3d 526, 532 (Tex.App.-Austin 2000).

125. The State of Texas including a general prayer for relief along with allegations that it sought "civil penalties" against the Defendants. No special exceptions were filed prior to trial and no objections were made to the State of Texas' requests for civil penalties at the time of trial.

126. The Defendants waived any objection to the State of Texas' request for civil penalties pursuant to Chapter 101 of the Texas Insurance Code.

127. The Defendants' failure to appeal or move for re-hearing on the Federal District Court's finding that the Unauthorized Health Care Programs were subject to regulation by the State of Texas waives any objection to the State's claims and further judicially estops the Defendants from objecting to the State's assertion of jurisdiction.

Signed on July 26, 2002.

/s/
Scott H. Jenkins
Judge Presiding

EXHIBIT A - 5

for that place.

Q. Did you remove the case to federal court? And why did you do so?

A. We removed the case to federal court because there were federal issues and questions that we felt we needed to establish. One of those things we needed to establish was that these were, in fact, single employer plans, and we would not be able to make that determination in state court.

MR. RAMIREZ: Would you please pass that over to me, please?

A. One of the items that we had to establish, of course, were that these were single employer ERISA plans.

Q. (BY MR. RAMIREZ) How were these plans formulated?

A. These plans were formulated by Mr. Michael Mangawang, who is an insurance actuary, enrolled actuary, with years of experience in formulating these plans. The plans that were formed were only a guide because UEVEBA is only a trust. We have no control over anyone or anybody. And we do not we cannot enforce our will upon anyone. We are simply a bank.

Now, in accordance to Donovan v. Dillingham, which you will see on Exhibits --

Your Honor.

THE COURT: Yeah, I can review that myself. Why don't we move on to the next item.

MR. RAMIREZ: Okay. Then, Your Honor, I'd like you to take judicial notice of 29 U.S.C. 11442 (b) (2)

THE COURT: Well, you can cite me to the statute and show me the statute and argue the statute at the conclusion.

MR. RAMIREZ: Okay.

THE COURT: Why don't you go on with the factual testimony at this time.

MR. RAMIREZ: Okay.

Q. (BY MR. RAMIREZ) Are you a fiduciary of UEVSBA I?

A. Yes.

Q. Do you have personal knowledge of the administrative requirements of a single employer plan?

A. Yes.

Q. In accordance to those administrative requirements, will there be any consequences to the employers and the plan participants if this injunction is granted?

MR. FULLER: I'll object. That calls for a legal conclusion.

EXHIBIT A - 6

COPY

NO. GV2-00903

THE STATE OF TEXAS, Plaintiff,	IN THE DISTRICT COURT OF
vs.	TRAVIS COUNTY, TEXAS
AMERICAN BENEFIT PLANS, et. al., Defendants.	53rd JUDICIAL DISTRICT

ORDER DENYING RHONDO/MANGAWANG'S REQUEST FOR RELEASE OF INFORMATION TO FILE FORM 990 FOR THE 26 U.S.C. §501(C)(9) TRUST OF 649 SINGLE EMPLOYER ERISA PLANS CURRENTLY UNDER RECEIVERSHIP

The Court considered the above-entitled motion filed by John B. Ramirez, a/k/a Johnny Rhondo and Jose Michael Mangawang. The Court finds that Movants have waived, in writing, any request for hearing on the motion and have requested that the Court take this matter under submission. The Court finds that Respondent, Robert Loiseau, Special Deputy Receiver for American Benefit Plans, et al., responded in opposition to the motion and, likewise, requested that the Court take the motion under submission. After considering the motion and the SDR's response, the Court finds that the Motion should be denied. It is

ORDERED that the Rhondo/Mangawang Form 990 Motion is DENIED.

Signed the 14 day of August, 2002.

/s/
JUDGE PRESIDING

[DATE STAMP]

COPY

PROPER NOTICE GIVEN, NO HEARING HELD BY AGREED SUBMISSION.
RECOMMENDED.

SIGNED ON THE 12th DAY OF AUGUST, 2002.

/s/ Tom Collins
TOM COLLINS
RECEIVERSHIP SPECIAL MASTER

EXHIBIT A - 7

COPY

NO. GV2-00903

THE STATE OF TEXAS, Plaintiff,	IN THE DISTRICT COURT OF
vs.	TRAVIS COUNTY, TEXAS
AMERICAN BENEFIT PLANS, et. al., Defendants.	53rd JUDICIAL DISTRICT

ORDER GRANTING SPECIAL DEPUTY RECEIVER'S APPLICATION FOR AUTHORITY 1) TO USE AN ALTERNATIVE HEALTH PLAN BENEFIT PROOF OF CLAIM PROCESSING PROCEDURE; AND 2) TO CLASSIFY CLAIMS

The Court, after notice and hearing, considered the Special Deputy Receiver's Application for Authority 1) to Use an Alternative: Health PIan Benefit Proof of Claim Procedure; and 2) to Classify Claims (the "SDR's Application").

The Court finds that it has jurisdiction over the parties and causes of action herein. The Court finds that the Special Deputy Receiver has provided notice of the Application all parties on the Court-approved certificate of service, to all parties known, to be in litigation with any of the Receivership Defendants, to numerous representatives of state departments of insurance throughout the United States, to representatives of the United States Department of Labor, to the United States Internal Revenue Service, and to all other parties identified in the certificate of service attached to the Application.

[DATE STAMP]

The Court finds that based on the Receivership Defendants' failure to maintain adequate business

records, the limited resources of this receivership estate, the number of potential claims against the receivership assets and the expense and delay in processing the claims, it is in the best interst of the receivership estate and its creditors for the Special Deputy Receiver to use an alternative health plan benefit proof of claim processing procedure. The Court further finds that given the ongoing expense of administration, American Benefit Plans principals' continued efforts to overturn continued efforts to overturn the receivership and conceal assets, and the extraordinarily high expense involved in attempting to recreate business records and process Proofs of Claims, the creditors generally will receive in the aggregate, under the Special Deputy Receiver's pruposal, no less than they would have been entitled to had the Proofs of Claims been processed exactly according to the alleged written agreements.

The Court finds that approved Proofs of Claims for health plan benefits and unearned premium should be classified as falling under Class 2(i) of Section 8, Article 21.28 of the Texas Insurance Code.

The Court finds that the Special Deputy Receiver does not anticipate having sufficient estate assets to pay all Class 2 claims. The Court finds that approving or denying claims categorized as Clas 3, 4 or 5 under Section 8 of Article 21.28 of the Texas Insurance Code would be an unnecessary waste of estate assets. The Court finds that the Special Deputy Receiver should not be required to process claims categorized as Class 3, 4 or 5 unless and until such time as the Special Deputy Receiver determines that sufficient assets are available to pay claims classified below Class 2 claims. The Court finds that the Special Deputy Receiver should be given discretion to process and approve claims falling under Classes 3, 4 or 5 in the event it would allow him to collect assets or minimize expenses. The Court finds that Class 3, 4 and 5 claimants should have an opportunity to contest the classification of their claim, and finds that the Special Deputy Receiver should notify claimants falling under Classes 3, 4 and 5 of their classification within no

less than one year from the Proof of Claim filing deadline, October 31, 2002.

The Court finds that the Special Deputy Receiver's Application is meritorious and should be granted. It is

ORDERED, ADJUDGED AND DECREED as follows:

1. The Special Deputy Receiver's Application is GRANTED;

2. The Special Deputy Receiver shall process and approve Proofs of Claims for health plan benefits, pursuant to the study attached to the Application and admitted into evidence;

3. The Special Deputy Receiver shall classify approved Proofs of Claims for health plan benefits and unearned premiums as falling under Class 2(i) of Section 8 of Article 21.28 of the Texas Insurance Code;

4. The Special Deputy Receiver shall not process claims that he determines fall under Classes 3, 4 and/or 5 of Section 8 of Article 21.28, although he is hereby granted the discretion to do so in the event that, in his opinion, it would allow him to collect estate assets or minimize the estate's expenses;

5. The Special Deputy Receiver shall notify claimants who, in his determination, fall under Class 3, 4 and/or 5 of such determination within one year of October 31, 2002;

Signed the 24 day of October 2002.

/s/

JUDGE PRESIDING

PROPER NOTICE GIVEN. HEARTNG HELD.
RECOMMENDED.
SIGNED ON THE DAY 23rd OF Oct. ,2002.

COPY

/s/ Tom Collins
TOM COLLINS
RECEIVERSHIP SPECIAL MASTER

EXHIBIT A - 8

Jose MONTEMAYOR, Commissioner, Texas Department of Insurance, et al., petitioners, v. CORPORATE HEALTH INSURANCE, et al.

NO. 00-665.

June 24, 2002.

Case below, 215 F.3d 526.

On appeals for writ of certiorari to the United States Court of Appeals for the Fifth Circuit. Petition for writ of certiorari granted. Judgment vacated, and case remanded to the United States Court of Appeals for the Fifth Circuit for further consideration in light of *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. ___, 122 S.Ct. 2151, ___ L.Ed.2d ___ (2002).

EXHIBIT A - 9

IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

No. 98-20940

CORPORATE HEALTH INSURANCE, INC.; AETNA HEALTH PLANS OF TEXAS, INC.; AETNA HEALTH PLANS OF NORTH TEXAS, INC.; AND AETNA LIFE INSURANCE COMPANY,
Plaintiff - Appellees - Cross-Appellants,

versus

TEXAS DEPARTMENT OF INSURANCE,
Defendant - Cross-Appellee,

JOSE MONTEMAYOR, Commissioner of the Texas Department of Insurance; JOHN CORNYN, Attorney General, State of Texas,
Defendants - Appellants - Cross-Appellees.

Appeals from the United States District Court
For the Southern District of Texas

December 16, 2002

ON REMAND FROM THE UNITED STATES SUPREME COURT

Before HIGGINBOTHAM, Circuit Judge, and ATLAS, District Judge.[1] Per Curiam:

This case is before us on remand from the

[1]District Judge of the Southern District of Texas, sitting by designation. This matter is being decided by a quorum, 28 U.S.C. § 46(d).

Supreme Court,[2] for further consideration in light of *Rush Prudential HMO, Inc. v. Moran.*[3] Although the Court vacated our opinion in its entirety, only one holding of our opinion in *Corporate Health v. Texas Department of Insurance*[4] was affected by the Court's opinion in *Moran*: that the provisions of the Texas statute allowing independent review of HMO's medical necessity determinations are preempted by ERISA.

In determining that the independent review organization provisions of the Texas statute were preempted, this court made a three step inquiry. We began with a determination that IRO provisions "related to" ERISA, and were therefore preempted.[5] We then determined that the IRO provisions were insurance regulations under ERISA's saving clause.[6] Finally, we determined that the IRO provisions were nonetheless preempted because they conflicted with a substantive provision of ERISA.[7] Specifically, we held that the IRO "creates an alternative mechanism through which plan members may seek benefits due them... the identical relief offered under § 1132 (a)(1)(B) of ERISA."[8] We concluded: "As such, the independent review provisions conflict with ERISA's exclusive remedy and cannot be saved by the saving clause."[9]

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[2]Montemayor v. Corporate Health Ins., __ U.S. __, 122 S.Ct. 2617 (2002).

[3]__ U.S. __, 122 S.Ct. 2151 (2002).

[4]215 F.3d 526 (5th Cir. 2000).

[5]*Id.* at 537.

[6]*Id.* at 538.

[7]*Id.* at 539.

[8]*Id.*

[9]*Id.*

Moran made the same three inquiries in examining a similar Illinois statute. As we found in examining the Texas statute, *Moran* found that the Illinois statute related to ERISA, but was an insurance regulation under the ERISA saving clause.[10] However, in examining whether the statute was preempted as conflicting with ERISA's exclusivity of remedy, the Court held that it was not. While *Moran* recognized that any state law that created a new cause of action or alternative ultimate remedy would be preempted by ERISA, it held that the independent review provision did not offer a new cause of action or ultimate remedy:

> But this case addresses a state regulatory scheme that *provides no new cause of action under state law and authorizes no new form of ulitmate relief.* While independent review under § 4-10 [of the Illinois statute] may well settle the fate of a benefit claim under a particular contract, the state statute *does not enlarge the claim beyond the benefits available in any action brought under § 1132(a).* And although the reviewer's determination would presumably replace that of the HMO as to what is "medically necessary" under this contract, *the relief ultimately available would still be what ERISA authorizes in a suit for benefits under § 1132(a).*[11]

It is at this juncture that *Moran* parts company with our holding, unless the Texas statute differs in a relevant way from the Illinois statute at issue in *Moran*. As our description of the Texas statute made clear, there

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[10] *Moran*, 122 S.Ct. at 2159, 2164.

[11] *Id.* at 2167 (internal citations omitted, emphasis added).

are no relevant differences between the statutes.[12]

On remand, Corporate Health argues that the IRO provisions of the Texas statute are preempted as they apply to self-funded ERISA plans and federal employees under FEHBA. It is correct on both counts. First, application of the Texas statute to self-funded ERISA plans is preempted. Again, the Court in *Moran* found, as did we with the Texas statute, that the independent review provisions "related to" ERISA plans and were thus generally preempted. *Moran* also notes that ERISA's saving clause does not apply to self-funded ERISA plans.[13] Therefore, ERISA forecloses application of the Texas IRO provisions to self-funded ERISA plans.

Second, *Moran* did not examine FEHBA preemption, and nothing in the *Moran* opinion casts doubt upon our opinion regarding FEHBA preemption. Like ERISA, FEHBA also has a preemption clause for state laws that "relate to" FEHBA plans.[14] However, unlike ERISA, there is no saving clause for insurance regulation in FEHBA, and therefore FEHBA preempts the IRO provisions.

In sum, the *Moran* opinion requires that our opinion be modified in part. We hold that the IRO provisions of the Texas statute are not preempted by ERISA because they are within the saving clause of ERISA and do not offer an additional remedy in conflict with ERISA's exclusive remedy. Because self-funded

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[12]One such difference would be the creation of a new cause of action. However, we specifically held that the Texas statute does not create a cause of action for the denial of benefits. *See Corporate Health*, 215 F.3d at 534, 539. On remand, Corporate Health concedes that there are no relevant differences between the statutes and that the *Moran* opinion dictates that we find that the IRO provisions are not preempted.

[13]*Moran*, 122 S.Ct. at 2162 n.6.

[14]5 U.S.C. § 8902(m)(1) (1999).

ERISA plans are not covered by ERISA's saving clause, ERISA preempts any application of the IRO provisions to self-funded plans.

Accordingly, we REINSTATE our opinion as modified herein.

EXHIBIT A - 10

70 8/3/01 Employer Agreement United Employers Voluntary Employee Benefits Association - Arana Durdsen General Contractor

71 1/1/02 UEVEBA Defined Contribution Health and Welfare Limited Benefit Medical Plan Adoption Agreement – Baird Independent School District

72 12/1/01 UEVEBA Defined Contribution Health and Welfare Limited Benefit Medical Plan Adoption Agreement – Brown's Concessions

73 10/1/01 Employer Agreement United Employers Voluntary Employee Benefits Assoc. – Camp Roofing

74 12/1/01 UEVEBA Defined Contribution Health and Welfare Limited Benefit Medical Plan Adoption Agreement – City of Kermit

75 12/1/01 UEVEBA Defined Contribution Health and Welfare Limited Benefit Medical Plan Adoption Agreement – Daryl J. Dunn

76 8/1/01 Employer Agreement United Employers Voluntary Employee Benefits Assoc. – Dynamic Ocean Services

77 7/1/01 Voluntary Employees' Beneficiary Assoc. Defined Contribution Health and Welfare Limited Benefit Medical Plan Adoption Agreement with Epic Contracting

78 12/12/01 UEVEBA Defined Contribution Health and Welfare Limited Benefit Medical Plan Adoption Agreement – First Baptist Church, Angleton

79 7/1/01 Employer Agreement United Employers Voluntary Benefits Assoc. – G & A Staff Sourcing Inc.

80 9/5/01 UEVEBA Defined Contribution Health

EXHIBIT A - 11

[4830-01-p] Published July 17, 2003

DEPARTMENT OF THE TREASURY
Internal Revenue Service
26 CFR Parts 1 and 602
TD 9079
RIN 1545-BA47
10 or More Employer Plans

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Final regulation.

SUMMARY: This document contains final regulations that provide rules regarding the requirements for a welfare benefit fund that is part of a 10 or more employer plan. The regulations affect certain employers that provide welfare benefits to employees through a plan to which more than one employer contributes.

DATES: Effective Date: These regulations are effective July 17, 2003.
Applicability Date: For dates of applicability, see §1.419A(f)(6)-1(g).

FOR FURTHER INFORMATION CONTACT: Betty J. Clary, (202) 622-6080 (not a toll-free number).

EXHIBIT A - 12

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
AUSTIN DIVISION

Case No. A-02-CA-220-SS

[DATE STAMP
FILED
MAY 22 2002
CLERK, U.S. DISTRICT COURT
WESTERN DISTRICT OF TEXAS
BY /s/_____
DEPUTY CLERK]

STATE OF TEXAS, Robert Loiseau, Special Deputy Receiver for American Benefit Plans, et al,
Plaintiffs

-vs-

ROBERT DAVID NEAL, et al,
Defendants

ORDER

BE IT REMEMBERED on the 22nd day of May 2002 the Court reviewed the file in the above-styled cause, specifically the State of Texas' Motion to Remand [#7], defendants' response [#11], and plaintiffs reply [#18], defendants' Request for Oral Argument [#12], cross-defendant Texas Department of Insurance's Motion to dismiss for lack of subject matter jurisdiction [#13], cross-plaintiffs' reply [#15], and cross-complainant J. Michael Mangawang's Request for Default Judgment [#16]. After considering the arguments of the parties, the relevant case law, and the case file as a whole, the Court enters the following order and opinion.

I. Factual Background

The State of Texas alleges defendants, including individual defendants Robert David Neal, Robert Neal Pointer, Jose Michael Mangawang, and John Baptist

Ramirez, a/k/a "Johnny Rhondo", are engaged in the unauthorized business of insurance in Texas as defined by Section 101.051 of the Texas Insurance Code, in violation of Section 101.102 of the Texas Insurance Code. Specifically, the State alleges the individual defendants design and market "health plans" in Texas, despite not being unauthorized to do so under the Texas Insurance and Administrative Codes. On March 6, 2002, the State filed its complaint in the 53rd Judicial District Court of Travis County, Texas. On April 2, 2002, defendants filed their Notice of Removal on the grounds that plaintiff's claims, although wholly grounded in state law, are preempted by the Employee Retirement Income Security Act (ERISA). 29 U.S.C. § 1132(a); 29 U.S.C. § 1144(a).

The State argues defendants' United Employers Voluntary Employees Beneficiary Association I (UEVEBA) is not an ERISA plan exempt from state regulation, but rather an unauthorized multiple-employer welfare arrangement (MEWA). Under Texas law, MEWAs are subject to state insurance regulations and require a certificate of authority. See Tex. Ins. Code Art. 3.95-2(a); *see* 29 U.S.C. § 1144(b)(6)(A)(ii). In this case, the United States Department of Labor, in a letter to Commissioner Jose Montemayor of the Texas Department of Insurance, plainly stated, "Texas may regulate the UEVEBA arrangement in accordance with applicable state law. *State's Motion to Remand, Exhibit B, Letter to Commissioner Montemayor*, March 18, 2002. Also, the Department of Labor stated that even if the UEVEBA plan were found to be an ERISA plan, "Title I of ERISA does not preclude the application of Texas insurance law or regulations." *Id.* Defendants, however, assert the State has mistakenly assumed the UEVEBA plan is a MEWA, and argue that this Court has exclusive jurisdiction to make this determination. Furthermore, defendants contend the State's complaint attempts to avoid federal jurisdiction by "artfully pleading" what is allegedly a federal cause of action "disguised as a state claim." *See Defendants' Objections*, at 1.

In addition to opposing the State's motion to remand, defendants filed a cross-complaint in this Court against Robert Loiseau, the state court-appointed Special

Deputy Receiver, and the Texas Department of Insurance. Cross-claimants Ramirez and Mangawang bring nine causes of action: (1) violation of procedural due process; (2) interference with ERISA fiduciary duties; (3) unconstitutional taking by freezing ERISA accounts; (4) interference with interstate commerce; (5) diversion and conversion of ERISA plan assets; (6) reckless endangerment of an ERISA plan; (7) fraud and deceit; (8) violation of due process; and (9) abuse of process. The record indicates cross-defendants have not been served, though cross-defendant Jose Montemayor, the Commissioner of the Texas Department of Insurance, has filed a motion to dismiss for lack of subject matter jurisdiction pursuant to Fed. R. Civ. P. 12(b)(1). The Court notes that on March 19, 2002, Judge Margaret Cooper of the 53rd Judicial District Court of Travis County entered an interim temporary injunction and continued the appointment of the Commissioner of Insurance as a temporary receiver.[1] The temporary injunction expires on May 28, 2002, and thus the parties have requested the Court to expedite its consideration of this matter before the expiration of the state court injunction.

II. Appropriateness of Remand

In its motion to remand, the State of Texas argues ERISA § 502(a) does not wholly preempt state regulation of defendants' for alleged unauthorized business of insurance. Furthermore, the State argues the principles of federalism and the State's Eleventh Amendment immunity warrant remand of this cause to state court. In addition, the State notes that preemption pursuant to ERISA § 514(a), even if applicable in the present case, is only a defense to state action and not a grounds for removal to federal court. In opposition, defendants contend the State has wrongly assumed the UEVEBA is a MEWA subject to state regulation, and that only a federal

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[1]Mr. Robert Loiseau has been named the court-appointed Special Deputy Receiver pursuant to Judge Cooper's order.

court can make the factual determination regarding the proper characterization of UEVEBA and the other plans in question.

The Court first turns to the issue of ERISA preemption of the State's claims filed in state court. Under ERISA § 502(a), state claims that seek relief identical to that found in § 502(a) are completely preempted. *See Giles v. NYL Care Health Plans, Inc.*, 172 F.3d 332, 337 (5th Cir. 1999). In this case, however, the State sued defendants in state court for unauthorized business of insurance, which is outside the ambit of § 502(a). The State cites *Butero v. Royal Maccabees Life Ins. Co.*, 174 F.3d 1207 (11th Cir. 1999) for a 4-part test to determine whether complete preemption is proper: (1) presence of an ERISA plan; (2) plaintiff must have standing to sue under the plan; (3) defendant must be an ERISA entity; and (4) the complaint must seek relief similar to that available under § 502(a). In this case, the State is not a beneficiary of the plan, and thus lacks standing bring a §502(a) cause of action. *See* 29 U.S.C. § 1132(a)(1)(B). Also, as discussed above, the State is not seeking to recover benefits or enforce its rights under the terms of the plan, and thus cannot be said to be seeking § 502(a) relief. Furthermore, the State correctly argues its lawsuit is *not* an enforcement action with a qualified medical child support order, the only § 502(a) action available to the State under the statute. 29 U.S.C. § 1132(a)(7). The pleadings in the record do not support defendants' assertion that the State's claims are essentially federal in character requiring federal jurisdiction, and thus the Court finds that complete preemption under ERISA § 502(a) does not apply to the case at bar.[2] Consistent with this holding, the Court finds that it lacks subject matter jurisdiction over the State's state law claims against defendants and that remand is appropriate.

The State also argues that the Eleventh

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[2]As an alternative holding, the Court finds that § 514(a) preemption, which is an affirmative defense, does not establish federal question jurisdiction to support removal.

Amendment immunity and federalism concerns weigh in favor of remand. Courts have applied the Eleventh Amendment to bar citizens of a state to file suit against the State in federal court without its consent; this interpretation is also applied to removal to federal court of a lawsuit filed by the State in state court. *See,* e.g., *Lewis v. Midwestern State Univ.*, 837 F.2d 197 (5th Cir.), *cert. denied*, 488 U.S. 849 (1988). The State also argues in the alternative that the Court should abstain from exercising jurisdiction under *Burford v. Sun Oil Co.*, 319 U.S. 315 (1943); *see Barnhardt Marine Ins., Inc. v. New England Int'l Surety of America, Inc.*, 961 F.2d 529 (5th Cir. 1992). Specifically, the State contends that it already has a comprehensive regulatory scheme over insurance matters, and notes the pending receivership proceeding and temporary injunction in state court. In light of the substantial state interest in the regulation of unauthorized business of insurance, the Court agrees that *Burford* abstention is appropriate as an alternative ground for remand of this cause.

III. Disposition of Cross-Claims

Commissioner Montemayor moves this Court to dismiss the cross-complaint for lack of subject matter jurisdiction pursuant to Fed. R. Civ. P. l2(1)(b). The Commissioner argues the cross-claims do not give rise to either federal question jurisdiction or diversity jurisdiction and, in any case, the Eleventh Amendment bars suit against the Commissioner in his official capacity. Cross-claimants Ramirez and Mangawang oppose the motion to dismiss on the grounds the Commissioner's motion "asserts a federal right" by asserting Eleventh Amendment immunity. *Cross-claimant's Opposition to Motion to Dismiss*, at 1. Cross-claimants contend the causes of action pled in the cross-complaint flow from the violations of due process by the Commissioner and the Special Deputy Receiver, who allegedly exceeded their authority to regulate MEWAs and UEVEBA under Texas law. Furthermore, cross-claimants argue this Court has subject matter jurisdiction over the cross-complaint under a plethora of

legal theories, and thus contend the motion to dismiss should be denied.

Because the Court finds it lacks subject matter jurisdiction over plaintiff's claims at the time of removal, it declines to address the merits of the cross-complaint filed by Ramirez and Mangawang. The resolution of all pending matters is better left to the 53rd Judicial District Court of Travis County, Texas, which this Court finds is the proper court of jurisdiction for this cause of action to proceed.

Accordingly, the Court enters the following:

IT IS ORDERED that the State of Texas' Motion to Remand [#7] is GRANTED, and this cause is REMANDED to the 53rd Judicial District Court of Travis County, Texas, for further proceedings;

IT IS FURTHER ORDERED that cross-defendant Texas Department of Insurance's Motion to Dismiss for lack of subject matter jurisdiction [#13] is DISMISSED AS MOOT, consistent with the Court's finding that it lacks subject matter jurisdiction over this cause;

IT IS FURTHER ORDERED that defendants' Request for Oral Argument [#12] and cross-claimant J. Michael Mangawang's Request for Default Judgment [#16] are DENIED.

IT IS FINALLY ORDERED that any and all remaining pending motions before this Court are DISMISSED AS MOOT.

SIGNED this the 22nd day of May 2002.

/s/ Sam Sparks
UNITED STATES DISTRICT JUDGE